Jorge Romero (Estate of Onystei Castillo-Lopez)

vs.

Berto Lopez, M.D.

Deposition of:

BERTO LOPEZ

January 10, 2019

PHIPPS REPORTING

Raising The Bar...

IN THE CIRCUIT COURT OF THE FIFTEENTH JUDICIAL CIRCUIT IN AND FOR PALM BEACH COUNTY, FLORIDA

CASE NO.: 2018CA011332XXXXMB

JORGE DOUGLAS MIRANDA ROMERO, as Personal Representative of the ESTATE OF ONYSTEI CASTILLO-LOPEZ, Individually, and as Surviving Spouse and Natural Parent and Guardian of CECILIA MIRANDA CASTILLO, and JORGE JASON MIRANDA, minor children,

Plaintiffs,

vs.

BERTO LOPEZ, M.D., BERTO LOPEZ, M.D., P.A., ALFRED TOMASELLI, III, D.O., ALFRED TOMASELLI, III, D.O., P.A., REYNOLD DUCLAS, M.D., COLIN G. BROWN, M.D., COLIN G. BROWN, M.D., P.A., SHERIDAN HELATHCORP, INC., TANVIR U. SALAM, M.D., and NUVIEW HEALTH, LLC,,

Defendants.
_____/

VIDEOTAPE DEPOSITION OF

BERTO LOPEZ, M.D.

Thursday, January 10, 2019
10:51 a.m. - 3:14 p.m.

Grossman, Roth, Yaffa, Cohen, P.A.
925 South Federal Highway
Boca Raton, Florida

Stenographically Reported By:
Richard Applebaum, RMR, FPR, CLR
Realtime Systems Administrator

APPEARANCES:

On behalf of Plaintiff:

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ALSO PRESENT: Steve Manno, Videographer; John Pacenti; Alfred Tomaselli, III, D.O.

I N D E X

Thereupon,
the following proceedings began at 10:51 a.m.:

THE VIDEOGRAPHER: We're now on the record. The time is 10:51 a.m. Today's Thursday the 10th day of January, 2019. We're here at 925 South Federal Highway, Suite 350, Boca Raton, Florida, for the purpose of taking the videotape deposition of Berto Lopez, M.D, in the matter of Jorge Douglas Miranda Romero, et al., versus Berto Lopez, M.D. et al.

The court reporter is Richard Applebaum. The videographer is Steve Manno.

Will counsel please announce their appearances for the record.

MR. COHEN: Yes. Thank you.

My name is Gary Cohen, and I'm here representing Jorge Douglas Miranda Romero and his two children Cecilia and Jorge Jr. and the Estate of Onystei Castillo-Lopez.

MR. BARKER: Alex Barker here on behalf of Dr. Alfred Tomaselli.

MR. CHIMPOULIS: Thank you.

Jay Chimpoulis for Dr. Duclas, Dr. Brown, and Sheridan Healthcorp.

MS. PINEROS: Daniella Pineros on behalf of Nuview Health and Dr. Salam.

THE COURT REPORTER: Doctor, raise your right hand for me, please.

Do you swear that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

THE WITNESS: I do.

Thereupon:

BERTO LOPEZ, M.D.

having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. COHEN:

Q. Good morning, Doctor.

A. Good morning.

Q. Give us your name, please.

A. Berto Lopez.

Q. And give us your current address.

A. Professionally, 1501 Presidential Lane, Suite 21, West Palm Beach, Florida 33401.

Q. Okay. And your home address, sir?

A. 1746 Flagler Manor Circle, West Palm Beach, Florida 33411.

Q. Okay. And you are a physician?

A. I am a physician specializing in obstetrics and gynecology. Yes.

Q. Okay. As you know, you've been named as a defendant in this case. And I represent the Plaintiffs, who I've mentioned a minute ago. And I'm going to be asking you a number of questions today regarding background questions as well as training and experience and then leading up to the incident that happened in this case that eventually led to the death of Onystei Castillo-Lopez.

At any time during my questioning if I'm not making myself clear to you, if you don't -- if you think you don't understand my question, you'd like me to rephrase or reask the question, just say so.

A. Okay.

Q. And, for the record, you are representing yourself here by choice?

A. At this point; correct.

Q. At this point.

And I know you've had depositions before and you've been an expert witness even, I believe, before, so you understand the basics of how a deposition works.

A. Yes, I do.

Q. Again, because you have no counsel here, if at any point there's something that you need an explanation on, please let us know and we'll try to do the best we can.

A. Thank you for that.

Q. Are you currently in the active practice of obstetrics and gynecology?

A. I am.

Q. And do you work for yourself or is there a group that you work for?

A. I'm employed by my P.A., which is an S corp, so I'm, basically, self-employed.

Q. And is it Berto Lopez, M.D., P.A.?

A. Correct.

Q. Okay. Is there any fictitious name that hangs on your door that, you know, that you use?

Meaning, some people call it Florida Obstetricians or whatever.

Do you have any name like that?

A. No.

Q. Okay. Hospital privileges-wise, do you have hospital privileges presently?

A. No. I elected not to renew my hospital privileges at Good Samaritan Medical Center. And that was the only hospital I had active privileges

in at the time of this incident.

Q. Okay. St. Mary's prior to that --

A. Okay.

Q. They're both Tenet hospitals.

A. Yes.

Q. St. Mary's had taken away your privileges prior to the birth of Jorge Lopez -- Jorge Miranda?

A. I believe that's a mischaracterization.

Q. Why don't we do it this way, why don't you tell me what happened to your privileges at Good Sam?

A. Okay. Good Sam or St. Mary's?

Q. St. Mary's first.

A. At St. Mary's.

During the course of a maternal death, an investigation was begun and I was placed on precautionary suspension. And I chose to withdraw my privileges rather than go through their so-called fair hearing process, because members that are now part of the defendant class in that lawsuit included the former chief of staff Dr. Borrego, who was a trauma surgeon involved with the care and coordination of the treatment of this particular patient. The partner of Doctor -- I believe her name was Shaw -- was also a party to and part -- and

a defendant in the lawsuit that subsequently happened, as were either the -- certain members of what could have been impaneled as part of the hearing group. And there would have not been able to have gotten a fair hearing inside of the hospital policy process. So I made the decision to resign while under precautionary suspension.

Q. Okay.

A. Rather than -- and allow the legal system to decide in a much more impartial way as to whether or not the care and treatment I delivered met the standard of care.

Q. All right. Did you feel that the way the hearing was constituted that there was going to be a bias against you?

A. Without a doubt.

In fact, I had heard -- I'd been on staff for maybe -- more than 25 years. I had heard through the grapevine that some of the physician groups who politically I had clashed with in terms of privileging and credentialing some of their own members thought that this was an opportunity to get revenge, including one physician where I was -- I signed the intent to initiate litigation against, who was part of a committee that was very vocal

against me.

So I didn't think -- I thought with a jury stacked against me before we even got started, it made no sense.

And my legal counsel was the former hospital attorney for St. Mary's for over 30 years, and he knew some of the players, and agreed that the wiser thing to do would be to resign while under investigation. And that's what I chose to do.

Q. Okay. So did the Department of Medicine investigate that case?

A. They did.

Q. Is that the case that -- where a woman bled to death?

A. I'm not sure -- I think it was a little more complicated than that.

Q. The final result --

A. The name of the case is Ashley Perez and the -- and her representatives.

Q. And I have the Department of Medicine complaints in that regard.

A. Right. Right.

Q. I made it simple, in that without going through all the details, the obstetrical woman, patient of yours, wound up passing away; is that

correct?

A. At the end -- because of delays that were -- that occurred on the part of -- well, actually, because of the denial of the on-call surgeon as Wellington Regional Medical Center, because of the delay in timely transferring her because of an issue with the ambulance service, as well as the patient's stability caused by the delay in active transport, because of the failure of the on-call trauma surgeon, who by contract served as the intensivist, to timely see and evaluate this patient over the course of several hours, despite having been proven to have been in the unit itself evaluating other patients, yes, at the end the patient ultimately demised.

Q. And was the ultimate demise due to a massive bleed that wasn't repaired or wasn't taken care of?

A. The ultimate cause of death was bleeding, yes.

Q. Okay. And is that the case, sir, that the -- where the Department of Medicine filed a complaint against you where you consented to a judgment, not money judgment, consented to certain restrictions on your license?

A. Well --

Q. Your practice, I should say?

A. In the form of the consent, the consent agreement, I believe it's in the third paragraph, indicates that I neither agree nor deny any of the allegations.

The consent was an arbitration, where in order to -- it's kind of like a plea agreement, that I agreed that I would undergo certain conditions in order to avoid a trial. At which point the trial results would be uncertain, quite possibly --

Q. I'm talking the Department of Medicine, not a jury trial.

A. It's an administrative judge trial in the State of Florida.

Q. Right.

Go ahead.

A. Whereby I would bring my experts, they could bring -- the department could bring their experts.

Rather than going through the cost and the uncertainty of an outcome of a trial --

And I might add, I have an expert opinion by a very well respected OB/GYN in an independent case regarding this very case that supports that

nothing I did was wrong.

I made the choice to enter into a plea agreement in order to resolve the case.

Q. Okay. And so the board had charged you with what they felt was negligent handling of the case, but rather than go to a full hearing on it, final determination, you agreed to in effect settle it?

A. Well, it's a little more than that.

We had filed a response to their complaint, and in the response to that complaint we had provided defenses.

And rather than proceed with the cost and the uncertainty of an outcome of an administrative judge evaluation of the case, we chose to -- I chose to accept their terms, while not agreeing or admitting to liability or denying liability.

As I said --

I see you're looking at a copy of it.

You can read it into the record it you'd like.

Q. We will read parts of it in.

But it actually doesn't say one way or the other whether you were negligent or not, it doesn't mention those words; in other words, the fact that

you neither deny or agree to the allegations against you, it's not mentioned in the final order.

A. May I take a peek at that, sir?

Q. Sure.

A. Because I believe this is what it says exactly.

Part Three, and this is on page 2 --

Q. Right. I'm here.

A. "For the purposes of these proceedings Respondent neither admits nor denies the allegations of fact contained in the administrative complaint."

Q. Okay.

A. And that's exactly what --

You know, I was trying to say it in like regular talk rather than lawyer talk.

Q. I understand.

A. So the board accepted that I neither admitted nor denied, as part of the agreement. And it's a settlement before a trial.

Q. Well, let me read the next sentence. It says, "Stipulated Conclusions of Law," in other words that's what your counsel and you stipulated to with the state "Respondent admits" -- that would be you -- "admits that in his or her capacity" licensed -- "as a licensed physician he or she is

the subject to the provisions of Chapter 456, 458 Florida Statutes, and the jurisdiction of the department and the board," of course; correct?

A. Yes.

Q. Number two, "Respondent admits the" facts -- "that the facts alleged in the administrative complaint if proven would constitute violations of Chapter 458 Florida Statute."

In other words, you're saying if the facts that they laid out were proven, they would constitute violations of standard of care by the board?

A. Correct. If they were proven.

Now, if they were not proven, then the board's actions would be dismissed. As I've seen happen in other cases where I have been accused or alleged --

Q. We'll get to those.

A. -- of negligence care.

So you're presumed innocent until proven guilty.

So the presumption -- the language that's contained in here merely says that if proven these allegations.

But those allegations were neither proven

by a judge or not proven by a judge, as would happen in an administrative complaint.

Q. Okay. Now, as a result of that complaint and that order, which was entered in April -- excuse me -- in May of 2017, which was just a few months before Miss Castillo-Lopez was under your care at Good Sam, there were certain things that you agreed to as far as, number one, a reprimand; correct?

A. Yes. I accepted a letter of reprimand in my file.

Q. And you also agreed to do a certain number of continuing medical education in certain parts of medicine such as risk management, and that would be overseen by the board that you did them?

A. That's correct.

And I have completed all of them.

Q. Okay. And also in that order your surgical privileges under the Board of Medicine in the State of Florida were restricted in some regard; correct?

A. Yes. The obligation imposed was that I needed to have a Board certified OB/GYN present during surgical procedures.

Q. Okay. And so that -- surgical procedures include in your world of obstetrics and gynecology

would include what type of procedures?

A. I believe that a representation of what would constitute an operation was initially interpreted legally as a procedure performed in an operating room.

Q. Okay. Now, in any labor and delivery of a child you're aware, of course, that at some point during that labor and delivery there may be for various reasons a need for an emergency surgery?

A. Correct.

Q. And therefore -- and that could happen on a minute's notice, basically. Something happens, you quick have to make that decision.

And if you were in that position with that restriction on you, would you have to have already contacted an obstetrician to be available just in case or would you have them in the room or how did you handle that?

A. Okay. By agreement with the hospital and the doctors that made up the committee that is the medical executive committee, they were -- they accepted that in the event that a surgical procedure was going to be performed, that I had to have the Board certified doctor at the time of the performance of the surgery. There was not a time

limit. There was not a restriction as to at what point of the surgery the surgeon would have to be present.

In general, while on TV where commercials come every 15 minutes, maybe every 12 minutes, the action appears to be fairly rapidly. In the real world of a medicine if a snap decision that an intervention has to happen, it actually takes time for the nurses to prepare an operating room, it takes time for anesthesia to present themselves, it takes time to get the equipment, the instruments, the tools that the doctors are going to use. And in general, in the old days they would say you have a 30 minute window obstetrically speaking from the time of decision to the time -- the time of decision to the time of incision, while that standard generally doesn't apply.

Q. Right.

A. So if there was an incident where I felt surgery, even emergent surgery was indicated, and there are several areas in OB where that happens, and GYN, I was able to have a physician, Dr. Tomaselli, who agreed to cover me for that.

Q. What if Dr. Tomaselli was involved in his own surgery at the time, hypothetically?

A. Correct. Then there was an emergency room schedule at Good Sam which had a rotating group of physicians that would be available in the same amount of time as if the emergency were their own.

Q. Okay. Good Sam Hospital, which is the hospital we're referring to now, was at the time of the death of Miss Castillo-Lopez was the only hospital you had privileges at; correct?

A. Yes. Correct.

Q. Were they aware that you had resigned your privileges and the reason for your resignation of privileges at their St. Mary's Hospital?

A. I cannot speak to what they did and did not know, because I'm not on the credentials committee.

I believe -- yes, they --

I responded upon terminating my privileges at St. Mary's with a letter to the medical staff office at Good Sam, as is what was required by the bylaws. So they were notified. They were further notified of the Board of Medicine agreement that I had entered into. So they had at least two notifications involving the same case.

But I cannot speak to the exact issues in regards to a committee and a hospital -- I'm not on

the MEC --

Q. I'm just asking --

A. I'm not on the hospital privilege committee.

Q. I'm asking you what you're aware of; in other words, what you told them or what you know that they received.

A. Right.

They received the notifications as was required by the medical staff bylaw rules.

Q. Okay.

A. At both events, the resignation from another hospital and at the Board of Medicine consent agreement.

Q. Did anybody from administration at Good Sam question you in regards to the allegations made against you by St. Mary's?

A. I don't know how to answer that.

They were certainly present at a number of meetings, but -- when I received the Board of Medicine action and the plan for permitting me to continue to practice.

Q. What do you mean they were present, you mean present at meetings in front of the Department of Medicine?

A. No.

Q. I didn't think that was the case.

A. Within the hospital --

Q. Okay.

A. Okay. A hospital's like a country club. You have a group of people who decide who can be a member and what the members are allowed to do.

Let's say it's a golf and tennis club. If you apply for tennis privileges, then they will see if you're a decent enough tennis player to be part of the club. And if there's an issue involving your qualifications, then those are addressed by committee and there's a discussion.

A representative from the administration attends those meetings. So at one time or another, I'm certain, although I don't recall seeing who might have been the person representing the administration, but there was representation, they were aware of my Board of Medicine action, because I notified them, and they independently would have been notified by the Board of Medicine. And a plan was created whereby I and they were in agreement what would take place in order that if I were to perform surgery, that I would have met the criteria for the Board of Medicine requirements.

Q. The reason I'm asking the way I am is because both Tenet and St. Mary's hospitals are owned by -- excuse me -- both St. Mary's and Good Sam Hospital are owned by Tenet; correct?

A. Yes.

Q. All right. So the board at St. Mary's, a Tenet hospital, was going about a decision as to whether or not you had violated certain standards and were, you know, going to try to remove you from their hospital staff. And you chose, because of what you told us was bias, that you felt was -- for the reasons you felt it was present, that you chose to suspend your own privileges or resign your privileges?

A. Let me stop you there, Mr. Cohen. You've mischaracterized the process at St. Mary's.

The administration nor the hospital had made a determination --

Q. I didn't say that. I said they going to have a hearing.

A. Sir, if I may finish my answer, I'll offer you the same privilege.

May I?

Q. Please.

A. The hospital has a process. It's not up

to just the administration and it's not just up to the medical staff. It's a collaboration whereby you can go through a process if there is an issue about the care and treatment of a patient. And that process is intended to be, you're innocent until proven by a panel, a fair hearing panel, made up of members, that you have, in fact, violated one of the bylaw rules or have -- or they have a concern about you.

It never got to that stage, other than they were proposing to ask me to be involved in the fair hearing process.

I resigned because I did not feel that there could be -- in a hospital with that much chatter, where I was a solo practitioner and the largest OB/GYN group was my competitor, if you will, I chose not to go through that process.

Q. Okay.

A. So neither by one way or the other could I say the administration alone or the hospital staff alone had come to any sort of conclusion, as they had not heard any facts or evidence prior to my resignation.

Q. And I understand that. And you told us precisely that before, which was that you felt that

because of the biases you felt for the reasons you felt at St. Mary's that you would not get a fair hearing?

A. Correct.

Q. Did that woman die at St. Mary's, by the way, or at Wellington?

You mentioned Wellington before.

A. Right. The patient was declared dead at St. Mary's.

Q. Okay. And the allegations that were made against you at Tenet St. Mary's, which never went to a hearing, for the reason you stated, were those allegations known, if you know, to the people at the administration at Good Sam; in other words, the allegations that were created -- excuse me -- that were alleged against you at St. Mary's and your subsequent resignation, was the factual information, if you know, known to the Good Sam people?

A. I have no way of knowing professionally.

My duty was to follow the bylaw rules at the hospitals I was on staff at. I notified Good Sam timely of my decision to resign while under investigation. And it would have been incumbent upon them to hear whatever the hospital had to say. And certainly they had the opportunity to call me in

and have a discussion about what happened at St. Mary's.

Q. Okay.

A. To my recollection, they never queried me concerning the issues surrounding the other element.

But I could not -- you know, I'm not in a position to say.

Since you have spoke with their representatives, that may be a more appropriate question to ask the hospital or the administrators at Good Sam what they knew and when they knew it.

Q. Okay.

A. But it's certainly no secret, because it was disclosed immediately.

Q. Okay. Did you when you were -- when you had an obstetrical patient, any obstetrical patient, after you resigned from St. Mary's and after the Board of Medicine took what action it did that you stipulated to in regards to your limitations during surgeries ever tell your patients, any patients that you had, of the limitation on you, that if this does require a C-section, I'm going to have to call in another doctor because I'm not allowed to do this without --

A. And there were times that I did and there

were times that perhaps I didn't, depending on the type of surgery that was going to be involved.

Q. Right.

Do you know whether you ever had a discussion with Miss Castillo-Lopez in that regard at any time?

A. I don't recall one way or the other.

Q. Okay. Did you have a standard that you used at the time that, you know, that your standard was I would tell everyone that in case something happens or if I'm taking you to surgery I have to have another doctor there because of a restriction on my privileges; did you ever discuss that with any others?

A. Of course. Of course.

And like, for example, in the case of Mrs. Castillo-Lopez, her last baby was born at St. Mary's and her aunt's babies were born at St. Mary's, and her aunt was a physician in the community.

Q. Okay.

A. And when I no longer delivered at St. Mary's, I offered an explanation, if asked. Or sometimes I would volunteer it if it's someone that I knew that I delivered at one hospital but I'm now

delivering at another hospital.

Q. Okay. So -- but in this particular case you don't recall discussing that subject matter with either Miss Castillo-Lopez or Dr. Irma Lopez; is that correct?

A. Correct, I don't have a specific recollection. Which doesn't mean that it didn't happen.

Q. Well, if -- hypothetically if there's testimony which would be -- obviously not Miss Castillo-Lopez, but Dr. Irma Lopez or the husband, Jorge, which they testified that you never had that discussion with them, you could not be in a a position to counteract that, correct, contradict that?

A. I have not seen their depositions.

Q. They haven't been taken yet.

A. Okay.

Q. If they were to --

Let me finish to make sure the question comes out properly.

If they were to testify that they were never notified by anybody, including you, of that issue regarding your restriction of license and privileges, that you never talked to them about

that, you are not in a position to deny that because you don't remember one way or the other; is that fair?

A. Well, when you say a restriction of privilege, there wasn't a restriction of privilege. There was simply an obligation of having a Board certified OB/GYN to be with me at the time of the surgical procedure.

Q. Isn't that's a restriction; in other words, you can't operate by yourself --

A. The many words --

Q. Hang on. Let me finish now.

A. Okay.

Q. You're restricted by the Department of Medicine, but also by Good Sam, you were restricted from doing surgeries by yourself?

A. Correct.

Q. So that is a restriction in that regard?

A. In that regard, sure.

I apologize for that.

Q. And so, going back to my question, if hypothetically Miss -- Dr. Lopez or -- Irma Lopez or Mr. Jorge Miranda Romero, the husband, were to testify that that was never discussed with them by you or anybody else from Good Sam, you are in no

position to refute that; is that fair?

A. No, because, as you know from -- well, you don't know.

Most of the visits by the patient she was by herself. She was not with her husband and she was not by Dr. Irma Lopez.

So to the degree that I did not discuss that in front of Dr. Irma Lopez, I don't ever remember seeing Dr. Irma Lopez come to my office during the course of this pregnancy. And I can only recall maybe one visit where I physically saw her husband at the time attend a visit for an ultrasound prior to the birth.

Q. Okay.

A. So the rest of the visits, and there's, I believe, more than ten, the discussion, if it would have happened, would have happened quite possibly very early in her pregnancy if she were -- usually it would come up when I would say I no longer go to St. Mary's, and I would explain why.

And in regards to this patient, she lived in Jupiter. Her aunt, for whom she worked for, worked out of Jupiter Hospital, did all of it -- they both were, you know, in close proximity to a hospital that they had the choice of seeing someone

else, someone closer to home, but made the chose not to.

Q. They made the choice not to. But you don't know if they were given the opportunity to know about what had happened to your privileges, correct, you don't know one way or the other?

A. Well, as I said, I have an independent recollection.

But I do have a recollection of discussing that I was no longer doing deliveries at St. Mary's, and that was a discussion. And as to the why, I was quite honest about it.

Q. Well, in this case?

You said you don't remember.

A. It all cases. All patients that I had that I delivered at Good Sam that I prior delivered at other facilities.

Q. Well, you told us just a little while ago that you don't remember in this case one way or the other whether you discussed it with this patient.

A. I don't remember the specific time and data that would have happened.

Q. That's not what you said, though.

You said you don't remember discussing it at all.

Now you're saying that you did discuss it but you don't remember the date.

A. Right.

I'm glad it's on tape. Because that's not what I said.

Q. It is on tape. And it's on also a court reporter.

So tell me what you are saying, are you saying that you know you did discuss it with her now, or that you don't know one way or the other?

A. I don't have -- I probably discussed it with her. I do not have an independent recollection as to the date and time.

The question invariably came up as to why aren't you delivering at St. Mary's any more. And I would answer it honestly.

Q. What would you tell them?

A. I would tell them because -- that there was an issue with a care of a patient at St. Mary's and at the time I had restrictions that wouldn't allow me to do deliveries at St. Mary's at this time, and I had other restrictions at other places that would involve having an assistant in the event of a surgery.

Now, in her case we anticipated a vaginal

delivery. And at the time of her late pregnancy there was no reason to suspect that she would need a Cesarean section, let alone a hysterectomy.

Q. Okay. Although, in all fairness, Doctor, any labor and delivery could wind up in a C-section for many different reasons?

A. Correct.

Q. And even after the C-section --

Even after a normal vaginal delivery there are also many reasons that a patient may need to be taken to surgery?

A. That's correct.

Q. Did you discuss with -- can you tell us that you discussed with Miss Castillo-Lopez that in the event of this having to be an emergency C-section or some other operative procedure you would have to have another doctor come by and why?

A. I don't recall having a discussion in that detail.

She was a medical assistant who had a fairly substantial knowledge of surgery. I forgot whether her training in Cuba was as a nurse. But she knew that a surgeon, if there was a Cesarean section, would not be there alone.

But I don't have an independent

recollection that I went to the detail that we're going through in this deposition.

Q. In the administrative complaint that we talked about regarding the patient at St. Mary's there is a paragraph that talks about -- let me get it so I can quote it exactly --

By the way, you were in the midst of doing continuing medical education as required by the settlement with the Department of Medicine at the time that you took care of Miss Castillo-Lopez, do you know?

A. Yes.

Q. Okay. And where were you doing that?

Is it an on-line thing or was it at a --

A. No. No. I attended some conferences. No.

Prior to the consent order I had independently taken a course, which is called the simulation course, to management of postpartum hemorrhage and postoperative complications. And that was done at Orlando -- in Orlando, Florida at Celebration Hospital in 2015, where they had these highly sophisticated dummies, which were hooked up to computers, and there were four major subjects, one of which was postpartum hemorrhage.

Q. Okay. But at the time that you were taking care of Miss Castillo-Lopez, based on the order from May of 2017, and you took care of her, obviously, just a short while afterward, were you still undergoing the required continuing medical education?

A. Yes.

Q. Were you also subject to any requirements for community service?

A. No.

Q. Had you been previously with the Board of Medicine, had they previously demanded that you perform a number of hours of community service on a different case?

A. Yes.

Q. How many times did that happen?

A. Once.

Q. Okay. And how many hours did they require of you, do you recall?

A. 200 hours.

Q. And that was the case if I'm -- about 2004?

A. Yes, sir.

Q. And is that the case where a D and C was performed by you for a fetus that had died in utero;

is that the -- that case?

A. Yes.

Q. Okay. And my understanding from reading the complaint in that case is that you had done -- you had determined that the child was not viable, was dead, the fetus, and that you were going to perform a D and C to remove the fetus?

A. Correct.

Q. And that subsequent to the D and C the patient involved actually passed -- a numbers of weeks subsequent, that patient actually passed a fetal head and fetal arms and legs out of her vagina?

A. Correct.

Q. Okay. So can you explain how that happened, how you did a D and C on a fetus and didn't actually see the fetus?

A. Well, just immediately prior to performing this operation the patient had had an ultrasound done at Palm Beach Gardens Medical Center. The fetal size by the radiologist was between 12 and 13 weeks size.

Q. Okay.

A. And I used a closed container technique with a large bore suction catheter. So all of the

parts would not be recognizable, since they would partly be in a plastic container and they may have been in some capacity crushed by the suction and turning process of how the -- it's like a vacuum cleaner that you turn and materials get sucked out. So you would not necessarily identify all of the parts that are contained within the container. And after that I took out remaining parts using a Winn forceps as part of my surgical procedure. So all the parts were not identified.

Q. Okay. So do you send that to pathology?

A. Yes.

Q. And did they identify the parts?

A. They did not identify all of the parts, no.

Q. Did you call the -- did you --

Were you therefore concerned that you may not have gotten everything?

A. That was one concern.

The other concern was that since there were two places where there was specimens, one was in a -- again, the canister of suction contents and then the second one from where I teased out tissue and materials using a Winn forceps, there were actually two collections of samples. It could have

also been nursing error, where they only submitted a portion.

My explanation and my understanding was, it could have been just a portion of the specimen was submitted and not the total specimen was submitted.

Q. Well, what came out of the lady a number of weeks later was a female fetus with a normal head, neck, abdomen, legs and back, all those parts, which is -- sounds like most of the fetus; right?

A. Correct.

Q. And when you do a D and C and the baby -- the fetus is expelled in the way you, you know, talked about it, how you do it, how is it that you would not see the head or the arms or legs or back, spine of the baby, how is that possible?

A. Because one of the techniques that can be used is involving a suction device, and that suction device can macerate, it chops off the parts so they would not be identifiable as individual parts.

Q. Okay. The Department of Medicine looked into that case and found that you did deviate from the standard of care in your performance of that D and C and follow-up care; correct?

A. Yes.

Q. And that was in 2004, as I said.

And that agreement -- there was a consent agreement in that case, too?

A. Correct.

Q. Okay. And do you agree in that case that you fell below the standard of care, or was it the same thing as the 2017 decision, do you recall?

A. I made the decision to enter into a consent agreement. And I believe the same paragraph and language is substantially the same, where I neither denied nor admitted that --

And, again, if you'll share it with me, I'll be happy to read it into the record.

Q. Sure.

A. "The Respondent," that's me, "waives probable cause and the filing of administrative complaint by the Department" -- I guess that could be interpreted that they didn't file an administrative complaint -- "which would have charged him with a violation." And that -- this is on page 340.

And on page 341 it says "Respondent neither admits nor denies the allegations of fact contained in the draft administrative complaint for purposes of these proceedings only."

So we could say that I waived the probable cause and that they never filed an administrative complaint by the Department, according to -- that's what the language says on page 340.

Q. But they were going to and they showed you a draft of it and that's when you settled it?

A. Correct. That's right.

Q. Okay.

A. That avoided the filing of an administrative complaint.

Q. Right.

A. And I neither --

Q. And that was the one where they -- you also stipulated that you would be required to perform 200 hours of community service within two years from the date of the final order; correct?

A. Yes.

Q. Now, in the complaint of 2017 -- not the complaint, but the final disposition of the case in 2017, which I've misplaced somewhere -- there was an issue raised -- there were words raised about -- let me get it exactly. I don't want to mispronounce it.

MR. COHEN: Let's go off the record for a second.

(Whereupon, an off the record discussion

was held.)

BY MR. COHEN:

Q. Okay. One of the other requirements, sir, of the 2017 order was that you should undergo an evaluation by the Florida CARES, capital -- all capitals C-A-R-E-S, a Board or a board approved equivalent evaluator.

What is that, Florida CARES?

A. Florida CARES, basically, you go in and you do two or three day it's like a Board recertification examination, where they -- it's divided up into four different parts. One part is that you do a physical exam on patients that they've selected that have known disorders, so that they can evaluate your ability to appropriately evaluate a patient. Another part might be questioning. Another part is a chart review. And then the fourth part, I believe, is like -- they make you take a number of psychological tests, personality tests, MM -- an MMP.

Q. Right.

A. Minnesota --

Q. Multi whatever.

A. Right; right; right.

Q. In this case, do you know what type of

evaluation was done, if it was ever done?

A. No, I haven't done it. They didn't put a time limit to have it done.

Q. Okay. This is now -- this was ordered, as I said, in May of 2017, and we're now in January of 2019.

Are you still under the restrictions that were imposed in 2017 by the board?

A. Yes.

Q. Okay. Have you attempted to get those restrictions released in any way?

A. Not yet, because I need to complete the Florida CARES or equivalent evaluation.

Q. Is there a reason you haven't done that?

A. Well, yes. There were a number of reasons. One reason had to do with the death of my father last year --

Q. Sorry.

A. -- and resolving his estate.

There were family reasons that predominantly pushed it off.

Q. So you have not yet --

I don't want to go into your family issues, your personal issues.

But suffice to say, you have not attempted

yet to go be evaluated by Florida CARES?

A. Correct.

Q. And you don't know --

Do you know what type of evaluation in this case -- the order in this case was going to be required; in other words, was there a specific evaluation that they were sending you for?

A. The four elements that --

Q. All four?

A. Well, I think for discussing this with others that have gone, they've generally at a minimum all four elements are reviewed. Then they go over the results of the review with you, and then they may make -- you know, they may say he needs more education in one area or another. If they think that you have an impairment problem, they may ask you to get your eyes checked or go to alcohol rehab or whatever they think the impairment is.

Q. Was there any impairment --

Did you have any impairment that was raised by the board or by anyone else?

A. No.

Q. Okay.

A. No, not to my knowledge.

Q. Okay. Well, that's what I'm asking is

your knowledge.

A. No.

Q. Do you have a current plan to go to Florida CARES to be evaluated in the way that they evaluate you?

A. I have -- it is my intention to do that.

Do I have a specific date and time?

Q. Yes.

A. Not as of yet, no.

Q. Okay. So currently -- going back to that -- currently you have no privileges to deliver babies at hospitals?

A. Correct.

Q. Do you have any hospital privileges at all?

A. No.

Q. Okay. So you perform GYN procedures and you perform obstetrical procedures.

Let's go through those.

Some GYN procedures require the patient being admitted to the hospital, I take it?

A. Correct.

Q. And if that is necessary, what do you do with the patient now?

A. I refer them to other doctors that can

perform them.

Q. Okay. When was it, by the way, that Good Sam --

In the case of Good Sam, did the -- who was it that told you that they were not going to keep your privileges in place?

A. I was the one, because it was time for me to renew my clinical privileges and I elected not to submit a reapplication for privileges.

Q. And you --

A. But just prior to that I had a precautionary suspension, which is typical when there is a maternal death. And, once again, it would have been an internal process where they would have had the case evaluated independently.

Q. And you didn't want to go through that procedure for what reason?

The procedure that you would have to go through to get your license reinstated from suspension, why did you choose not to go through that?

A. Okay. Let me answer it this way, it's not a licensing issue.

Q. Privileges.

A. It is a privileging issue.

And the difference is, the hospital has no licensing power, to my knowledge.

Q. I understand that. I used the wrong word.

Let me rephrase my question so you can -- I used the wrong word.

Your license -- your privileges to practice at Good Sam were temporarily suspended pending an investigation, I take it?

A. Correct.

Q. And you chose rather than to go through the investigation process and be subject to whatever restrictions they would place or asking you to leave the staff, rather than that you chose to resign your privileges; is that correct?

A. Correct.

Q. Okay. Why?

You told us why at St. Mary's.

Is it the same thing at Good Sam, that you felt it was biased against you?

A. No. There were several things that had changed between those times. One thing that had changed is, there is a new model of medicine, where many doctors quit doing things at hospitals. For example, Dr. Lopez, the internal medicine doctor who's related to the deceased, sometimes she sends

her patients to be admitted to the hospital, but yet it's a hospitalist service that takes care of those patients while they're in the hospital.

Q. Right.

But I'm talking obstetrics and gynecology.

A. That's the trend that has --

The same trend is happening in my specialty, where many doctors have chosen to contract out with an OB/GYN hospitalist group, where you can focus your energies and times on office care. And if a patient needs hospital care, the patients will present themselves to the hospital by contract with this group, and they would take care of your patient. And then when they're finished with whatever it is -- say the woman is pregnant, they'll deliver the baby -- they'll round on the patient, deliver the mother, and send the mother back to you for postpartum care.

Q. Tell us in Palm Beach County, if you would, what hospitals do that?

A. Bethesda, which I don't go to; Palms West; JFK in Lantana. Those are the three that I know that the group that I contracted with provide services.

Q. Okay.

A. There's several in South Florida. That's -- those are just the ones that come to mind.

I know that there's hospitalist contracts out in other places, for example, at Lakeside Hospital there's a hospitalist service.

Q. There are hospitalist services all over the state. But specifically OB/GYN hospitalists?

A. That's what I'm talking about. I'm talking about exclusively OB/GYN hospitalists services.

Q. So you take care of a mother for eight, nine months in your office, and she's told that when it comes time to delivery they'll be some new doctor that will see her at the hospital?

A. Correct. We give them a picture -- they have a pamphlet of the panel of doctors that would be on call. The same group, OB/GYN Hospitalist, it's a national group, I think it's out of South Carolina, if I'm not mistaken, the national headquarters, and they do this in a lot of places.

Q. And the name of that group is?

A. OB/GYN Hospitalists -- OBGHG. So I think is OB/GYN Hospitalist Group. But I think they go by OBG -- OBGHG.

Q. Okay. So Good Sam was not one of those

hospitals that went that direction?

A. No, Good Sam up to this point has not.

But they have been interviewed -- I mean, they've considered it on a couple of occasions and have elected not to go that route.

Q. Okay. And in that regard, the question that brought that about was, why did you decide not to contest the suspension of your license -- of your privileges at Good Sam; was it the same reason at St. Mary's, where you thought there was bias, or was there a different reason at Good Sam?

A. Okay. I'm going to ask you to rephrase the question because it seemed compound.

Q. At Good Sam -- at St. Mary's -- Tenet St. Mary's you told us why you resigned your privileges and what was going on, that you thought there was a bias, correct, in regards to if you had gone through the entire procedure of hearings at St. Mary's there were certain biases against you, for the reasons you stated earlier, and you felt it was easier just to resign; is that correct?

A. I think you mischaracterized it.

The reason is, I did not see how it was possible, when the head of the trauma service and the head of the hospitalist group for internal

medicine, who are now parties in a lawsuit, would not have rancor and finger pointing towards me and allow me to have a fair hearing.

As it comes out in that sort of a review process there are biases that are also of a political nature from competing OB/GYN groups.

I'm a solo practitioner.

Q. That's why I put it the way I put it.

A. So in St. Mary's that was the problem. Okay.

At Good Sam the decision was made based on several factors, none of which were related to the ones that were involved in St. Mary's.

Q. What wee the factors at Good Sam where you did not contest the suspension of your license -- of your privileges?

A. There were many. Some personal.

Q. Okay.

A. I was heading in that general direction anyway, because in general I would be on call more often than I would if I joined or contracted with the OB/GYN hospitalist group. That is the most common reason.

It's the same reason why internal medicine doctors contract with internal medicine hospitalists

groups, it's a trend that is very popular now, and it's one of the more popular trends in obstetrics and gynecology because --

Q. How popular is it with the patient?

I would imagine a woman who is going to give birth, going through a pregnancy and give birth, usually gets pretty attached to their obstetrician or the group of obstetricians that they're seeing. And instead of just, okay, now my water broke, I have to go to the hospital, I'm meeting a doctor for the first time that's going to do that delivery, how do your patients handle that?

A. Well, they have -- the patients are advised to go to the hospital and meet with the hospitalist before they deliver. That's one thing.

The second element is, that medicine has changed in its complexity. If you were to deliver at St. Mary's Hospital, there are at last count maybe 50 or 60 doctors that have hospital privileges there, the largest majority of them in a group practice. You have about a one in seven to one in ten chance that your favorite obstetrician, the guy that you wanted to go into that group, will be on call when it's time for you to deliver. So statistically speaking the days of the doctor that

you saw for your entirety of prenatal care is the doctor that you will see at delivery.

And let me just say this, one of the largest referral places for my own practice is the large OB/GYN groups, because the patient's see each doctor one time. And the largest group they see the patient -- I mean, they see a doctor or a nurse practitioner only one time. And then it's time to have your baby. Because they're a big group, they may have ten doctors, mid levels. And so by the time they're done rotating through all the providers, they're not going to get that one that they most like.

So that trend is gone.

Q. In your case they can't see you in the hospital because you have no privileges?

A. In my case that's correct.

Q. Do you tell your patients that you have no hospital privileges and that you cannot under any circumstance deliver them at a hospital?

A. Yes.

Q. Okay. Do you still take care of obstetrical patients?

A. Yes.

Q. Percentage-wise has that practice gone up,

stayed the same or gone down, since your license was -- excuse me -- your privileges were suspended at Good Sam?

A. I'm going to ask you to rephrase the question, please.

Q. The obstetrical part of your practice, has the -- percentage-wise has it gone up, stayed the same or gone down, since you had your privileges suspended at Good Sam?

A. I believe that it's gone down just a little bit.

Q. Okay. Gynecologic procedures that need to be done in the hospital, the same issue, you refer to that group that you have a contract with?

A. No, not necessarily.

In that regard, it depends on the type of surgery a patient may need.

Gynecologic patients still come to my practice for annual examinations, pap smears, problem, you know, infections, other general gynecologic concerns.

In the event that they need surgery, it depends on the type of surgery they need. In northern Palm Beach County we have certain doctors that are experts at robotic surgery. Not all the

doctors perform robotic surgery. I do not perform robotic surgery. Some of the doctors are specialized in problems with the urinary bladder, urogynecologists. Those patients are sent to the urogynecologist that I think do the best work. The patients -- some patients may have a malignancy or a pre-malignancy issue, and those I send to selected OB/GYN gynecologic oncologists, of which there's several groups in town now.

So I segregate them out based on need and who I think will deliver the services that would end up with the best outcome.

Q. The delivery of Jorge Jason Miranda, that's Miss Castillo-Lopez's little boy that was born on the day she died, technically the day before she died, because she died in the early morning hours of the next day, is that the last baby you delivered?

A. Yes.

Q. And were you immediately suspended after that by --

A. Yes. The next day, I believe. Yes, I think it was the next day, the following day.

Q. And an administrative complaint has been filed against you for that case, this case, by the

Department of Health?

A. Correct.

Q. And is that still pending?

A. Yes.

Q. Do you know what stage it's at, if I can put it that way?

A. The last I spoke to my attorney, they were negotiating the terms of a settlement.

Q. Are the proposed terms that you know of, do they include suspension of any operative privileges anywhere?

A. No.

Q. Do they exclude the delivery of children?

A. They do not.

Q. What do they exclude, proposed, anything?

A. I can't -- to my knowledge, they're not looking at any suspension whatsoever.

Q. So are you saying that they are going to --

Are there any disciplinary procedures that you're aware of that they have proposed?

A. Again, it's an active negotiation.

I believe it's going to be -- there's going to be a fine and there are going to be probably CME's involved. But I've been told as of

the last negotiation discussion, they're not talking about suspending.

I'm already on an obligation to have an OB/GYN present at the time of a procedure.

Q. There's a board of probation I think that they have, a separate board of probation, the call it --

A. Right.

Q. -- that has to decide whether you come off of that or not.

A. Again, there's many details of the process that you know better than I.

Q. Okay. But -- Okay.

A. But no, suspension is off the table.

MR. COHEN: Okay. Let's take a five minute break, if we can. We've been going for awhile.

THE WITNESS: Okay. Sure.

(Whereupon, a short break was taken.)

BY MR. COHEN:

Q. Okay. Now, in addition to the complaint that was made to the Department of Medicine which resulted in your -- the suspension of your operative privileges without another supervising OB/GYN in 2017, did that -- we talked about the woman who died

from bleeding -- ultimately from bleeding, and that the other physicians involved that you told -- the facts that you basically told us about.

Was there another woman that was subject to that same complaint?

A. I'm not sure I understand your question.

Q. Was it one patient that was being complained about or was it two patients that were being complained about?

A. It was -- that involved one patient who was transferred from one hospital to another hospital.

Q. Okay. Which was -- which hospitals?

A. She was transferred on the advice of Dr. Goad, the general surgeon, who did not come to the bedside and evaluate the patient, from Wellington Regional Medical Center to St. Mary's Medical Center.

Q. Okay.

A. So once -- the same patient transferred from one hospital to another on the advice of the consulting surgeon.

Q. Were there any other patients that were subject to that same disciplinary proceeding in front of the Department of Health?

A. No.

Q. How many times that you know of have patients died under your care after or during birth?

A. Two.

Q. The two we mentioned already.

Are there -- were there ever any others?

A. I did care for a patient that my partner took care of, delivered, that I performed CPR on, who died. But I think it would be a gross exaggeration to say that I cared for her, other than in her terminal moments.

Q. All right. And what partner was that?

A. Sebastian Kent.

Q. So the two patients would have been the one that we mentioned from 2014 where the 2017 order resulted in restriction of your privileges and the other one would be Mr. Castillo-Lopez?

A. Correct.

Q. Is there any allegation in a case called Ligonge, L-I-G-O-N-G-E?

A. Not against me, that I'm aware of.

Q. Okay.

A. Does she have another name?

Or I would know, because I've not been served.

Q. I'm just asking if you're aware of any.

A. No.

Q. A case by a patient named Buchanan?

A. Yes.

Q. And what is that case -- what is the current position of that case?

A. Judith Buchanan. That case was settled.

She had appendicitis. I do not perform appendectomies during pregnancy.

Q. How were you involved?

A. The surgeon --

I was her primary obstetrician.

I called the surgeon right away to evaluate her. And he allowed her to stay in whatever condition she was in overnight and did not operate until the following afternoon.

Q. And she died as a result?

A. No. She's alive.

Q. She's alive. Okay.

A. She's alive.

Her baby was born prematurely. And I think he died of prematurity.

But no. Judith Buchanan is alive and well.

Q. And has an action been brought against you

for that?

A. Not -- well, it was settled in -- yes, there was a lawsuit. This is going back, I think it was the '90s.

Q. Right. Okay.

A. Yes, there was a lawsuit. And we settled that lawsuit.

Q. Okay. Then there's a case also called Dominic Shelton versus you and others.

Are you aware of that case?

2012 that it was filed.

A. Yes. I think I was released from that lawsuit, if that's the one I'm thinking about.

That was the baby that was -- the baby that was born --

Q. A brain injured child.

A. Thirty-three weeker, who developed spastic cerebral palsy.

Yes, I was released from that case.

Q. And where was that baby delivered?

A. That baby was born at St. Mary's.

Q. Okay. There are some pleadings in that case which we pulled off the Internet in regards to Tenet St. Mary's had a motion in limine regarding the status of you as a former defendant in this

action; in other words, they didn't want the Plaintiffs to be able to raise that you had been suspended in the Shelton -- not in the Shelton case, but they didn't want it brought up in the Shelton case.

A. I was not suspended in the Shelton case.

Q. I said they filed a motion about that, that you had been suspended previously, and they didn't want that brought up in front of any jury in that case.

A. You mean --

No. I had been suspended in a case subsequent to Shelton, not before Shelton.

Q. But the case that you were suspended, is that the 2014 case?

A. Yes.

Q. And this --

A. This was a 2012 case.

Q. Right.

Were you suspended immediately?

A. In 2014?

Q. Yes.

A. Yes. When there's a maternal death, it's customary to do precautionary suspension.

Q. Okay.

A. Pending an investigation to evaluate -- you know, to do a root cause analysis, as they say in risk management.

Q. Okay. Did -- what happened to the woman in that case, Shelton?

A. The patient was admitted with premature rupture of membranes at approximately 33 weeks gestation. During the course of having an IV line, a central IV line flushed with a medicine called FlowCath, she had a respiratory arrest.

At the time of her respiratory arrest there was a hospitalist physician, an OB/GYN hospitalist, who presented to her room, evaluated the patient, but did not write a note.

The rapid response team noted that the patient -- that the physician came to the bedside and left while there was a ten minute active deceleration.

I was notified --

She was my patient.

Q. All right.

A. I was notified. And I was at Good Samaritan, which is a few miles, maybe two, three miles away, and rushed, and asked the operating room to be set up for a Cesarean section.

And I immediately arrived and performed, when the patient was transported to the operating room, an emergent Caesarean section, and delivered the baby.

I was never -- I was never suspended. No cause for action on the part of the hospital was ever found for my care and treatment.

There was a concern and I believe other issues with the other OB/GYN, who was, in fact, an OB/GYN hospitalist, with their lack of timely care in the face of a nonreassuring fetal heart rate pattern by a prolonged fetal heart rate deceleration almost ten minutes duration.

Q. Okay. And -- Okay. And that baby wound up with -- the allegation was that that baby was brain damaged as a result?

A. Correct.

Q. And did you testify in that case by way of deposition?

A. Yes.

Q. Did you give any sworn testimony in front of the Department of Medicine on the cases we talked about so far?

A. If you would list the cases, I would say yes or no to each one, because we've talked about

many different cases and I don't want to be confused.

Q. There was the one at St. Mary's that lead to your suspension.

A. That would be the Perez case.

Q. Right.

A. Okay.

Q. Did you testify in any proceeding in that case?

A. Yes. In a deposition I have.

Q. Okay.

A. As well as in front of Board of Medicine when we did the --

Q. Okay. And in the Shelton case you testified, or did you testify?

A. Okay. The Shelton case, I believe I gave a deposition.

Q. Right. Here it is. I just found it.

A. Yes.

Q. Here it is.

And in the -- in this case in front of the Board of Medicine have you testified?

A. It has not --

Q. Meaning the case involving the death of Onystei Castillo-Lopez.

A. No. It has not gone to that point yet.

Q. Okay. You do expert witness testifying?

A. I do.

Q. And tell me about that, as far as frequency, you know, plaintiff versus defendant, all those questions you get asked.

A. I've been doing it since the time my sister was a medical malpractice defense attorney representing St. Mary's in the early '90s. I initially did mostly defense work, because most of her friends were defense attorneys and then they may have been turned into plaintiff's attorneys. So I've been doing it for 26 years, something in that range.

Q. Okay. And how often?

A. Twenty-six, 27.

Q. How often do you do it?

A. I don't know the exact number of cases I've done overall. Probably -- I've reviewed probably over a thousand cases.

The majority of the time the physician has done nothing wrong and there's an outcome that's less than what people had expected. So most cases I find for -- the causation to be something other than physician negligence.

Most of the cases are referred to me now, I'd say 99 percent -- between 95 and 99 percent of cases are plaintiff cases, where plaintiff's attorneys has asked me to opine as to the care and treatment. I've been a standard of care expert for some time.

Q. And currently which lawyers locally do you get retained by?

A. Well, in the State of Florida, Morgan and Morgan. I most recently had been retained by -- I'm trying to think of the names. After awhile they run together.

Q. Searcy, Denney ever?

A. I have in the past, not recently.

Q. Okay.

A. Probably in the '90s I reviewed a case or two for them. But not local cases, cases out of Florida.

It will come to mind. I'm bad with names sometimes.

Q. Okay. Any defense lawyers you recall testifying on behalf of?

A. I've reviewed cases for Chimpoulis' firm.

Q. Okay. When was the last time?

A. It's been awhile. Again, probably in the

'90s.

Q. Go ahead.

A. I think it's Alex Rodriquez and Associates in Miami. Maria Tejedor in Orlando. Those are the names that come to mind.

Q. Okay.

A. Ken Levine in Boston, Massachusetts. I can't remember the first name of this lawyer, I think his name is Getz, G-E-T-Z, in Maryland, Baltimore, Maryland.

Q. Okay. How many times have you been named in a medical -- in a malpractice case?

A. I don't know.

Q. When you say you don't know, you don't know because you don't recall or because there's a lot that you don't remember the number or is it -- what is the reason?

A. I haven't ever actually counted.

I imagine it's less than ten and perhaps more than seven.

Q. Okay.

A. Because some cases get settled in the presuit period, and I'm not sure if you would define that as a lawsuit or not. Some I'm released during the case, as happened in the 33 weeker, because they

ultimately find that I presented no liability.

I had no liability in the case.

So I believe it may be more than seven and less than ten over my 30-something year career.

Q. How many judgments, if any, have been rendered against you after a trial?

A. Okay. I think we've settled during trial. I do not know that I've had ever a jury trial go to a judgment against me.

Q. Okay.

A. And you asked me a question, if I may add, that may cause me to draw a legal conclusion out of my expertise as an OB/GYN.

Q. Are you currently listed to testify in any cases as an expert witness?

A. Yes.

Q. And can you tell me how many and when?

A. I cannot, because what happens is, many cases settle and at various times, and some attorneys are very kind to let me know so I can release space on either a computer or a collection of papers and storage and some don't.

Q. Okay.

A. Many cases take years to resolve. So I don't know how many cases I'm actively named as an

expert upon.

Q. Okay. Do you have one coming up for testimony at trial any time soon?

A. I think there's one in February that's coming up. It's not a medical malpractice case. It's an office -- office staff negligent case in, I believe, Tampa.

Q. Medical office, I take it?

Medical office?

A. Yes. An OB/GYN medical office, where a medical office failed to timely get a patient in to be evaluated by a perinatologist, thus preventing her from making or having the option of a child being born with a very serious medical condition. Wrongful life case.

Q. Have you ever testified in a case involving the death of a mother during or immediately after delivery, as an expert witness?

A. Yes.

Q. Tell me, if you know, how many times, approximately?

A. I don't know the exact number.

Most recently one settled I think in December.

Q. And that was on behalf of the plaintiff

that you testified?

A. Correct.

Q. And you gave a deposition in that case?

A. No.

Q. What was the name of that case, do you recall?

Or the names of any of the cases where you testified where a woman --

A. I believe that that attorney's name is Cohen, Weinstein and Cohen.

Q. Okay. Any others that you recall where a woman died as a result -- during or immediately after her delivery?

A. Yes. I'm sure I'm done at least perhaps four or five that come to mind. I mean, none recently, other than there were two that I know that happened in Broward.

Q. Tell us a little bit about your medical background, where did you go to medical school?

A. The Medical College of Georgia in Augusta, Georgia.

Q. Where did you do your internship and residency?

A. Emery University affiliated program in Atlanta, Georgia.

Q. Are you still Board certified in obstetrics and gynecology?

A. I am through December of 2019.

Q. Do you plan on recertifying?

A. I just got recertified. I've been recertified continuously since the year 1990. I'm going on my what, 30th year almost.

Q. In this particular case have you reviewed -- what have you reviewed?

A. I have reviewed the medical records of Ms. Castillo-Lopez, including my office records for her prenatal care for this index pregnancy, and the hospital records at Good Samaritan Medical Center for her delivery that's the subject of this delivery. I've also gone back and looked at the ACOG -- American College of OB/GYN, of which I'm a member, some information about the management of postpartum hemorrhage according to one of their guidelines.

And, as I mentioned, in 2015 I took a simulation course that dealt with the management of postpartum hemorrhage using dummies, computerized dummies.

Q. Okay. Anything else that you reviewed in this case for this case?

A. Other than what I typically and normally would review on an ongoing basis.

Q. That's why I said for this case specifically.

A. Well, again, the subject of postpartum hemorrhage and maternal mortality is a big subject. There's a new big impetus to prevent mortality due to postpartum hemorrhage. It's the most common cause of maternal mortality, despite all the changes in blood banking and so forth. There have been several recent articles that headline some of the journals that I subscribe to and some what we call throw away journals.

Q. Do you fault anybody for the death of Miss Onystei Castillo-Lopez?

A. No.

Q. Including yourself?

A. Absolutely not.

Q. And her cause of death was what?

A. Well, that's the subject for someone else to opine. I'm not an expert on mortality.

I think she certainty died as a complication of her postpartum hemorrhage.

Q. Did you read the autopsy?

A. I did.

Q. Did that tell you what she died of?

A. No, because I don't think that the -- that that pathologist, which is, I think, the assistant medical examiner of Palm Beach County, who wrote that opinion, may have the full understanding of shock.

Q. Okay. Do you not think she was in shock by the end of her life?

A. Again, I'm not sure that I've finished my full opinions as to her proximate cause of death.

I saw no evidence of a pulmonary embolism.

But the manner in which she died did not seem to clearly fit the picture of an acute shock, in my opinion.

Q. The autopsy showed no evidence of pulmonary edema, did it?

A. Pulmonary edema?

Q. Pulmonary embolus. Excuse me.

A. Correct.

Q. What it did show evidence of was that the lady had retained pieces of uterus, retained cervical -- cervix, and that she basically bled to death, which resulted in shock and death.

That's what the autopsy found; correct?

A. That's the description. But I think it's

in error for a lot of very good scientific reasons. The first one of which, this patient did not manifest any vaginal bleeding sufficient enough that would have explained shock; that the pathology report failed to note that the supracervical hysterectomy was consistent with, again, some guidelines in the American College's postpartum hemorrhage management protocol, which is, it's up to the decision-making and opinion of a surgeon whether or not to take out or leave the cervix based on what would be most expeditious in light of their medical status at the time of the emergency hysterectomy.

Furthermore, the procedure that was performed that allowed a part of the lower uterine segment and the cervix to remain, there was the same type of suturing that is recognized as a form of controlling a postpartum hemorrhage; in other words, the remaining portion of the upper part of the cervix and the lower part of the uterus had Z line suturing, as you would sometime do if you wish to retain the uterus. And that's consistent with something that could be done.

It's also further noted in her operative note and the note of the anesthesiologist that at the conclusion of the case that there was hemostasis

intra-abdominally.

Some of the findings that the pathologist commented on, for example, the presence of blood in two areas of the patient's body, are common when you use the mechanical CPR device in a fresh postoperative patient, because the amount of pressure that's generated by the compression of the electronic CPR device can freely exceed the tensile strength of the suturing material that's holding a fresh postoperative patient. And in and of itself, I'm not quite sure that's the volume of blood in someone who just recently had been transfused to have caused her to go into life-threatening shock.

Q. Then what did?

A. I said on -- I have not finished my opinion or investigation as to her cause of death.

Q. Did she not massively hemorrhage?

A. Before surgery, yes.

And as the note from Dr. Duclas notes, that she was resuscitated fully, was oxygenating fully, was cognating and making movements postoperatively. That although she did have a metabolic acidosis, she appeared to be postoperatively clinically stable until the very acute event happened where she had a tremendous

change in status around 3 o'clock in the morning in the ICU.

Q. Right. We'll get to that a little at a time.

When she got to the operating room -- Strike that.

Let's start off before that.

When were you --

You delivered the child at 8:03, I think, p.m. on the night of the 26th of July, 2017.

And when were you notified that she was --

When did you notice that she was bleeding afterward?

A. I noticed as I was repairing her cervical lacerations and her mediolateral -- mediolateral laceration that episodically, not continuously, she would have these spurts of blood.

Q. Gushes as you called them?

A. Excuse me?

Q. You called them gushes.

A. Gushes. They were like periodic gushes, that subsequently was followed by intermittent crescendo, de-crescendoing uterine atony.

I remained at her bedside the entire time until she went to the operating room.

Q. Okay. Where was the massive bleeding coming from prior to surgery?

A. A segment of the lower -- a portion of the lower uterine segment would be my best guess, because you could actually see what appeared to be a little fountain --

Q. And what --

A. -- when the uterus was in a certain position.

Q. And what would cause that?

A. This patient started to push the baby out before she was completely dilated.

Q. She was told to, was she?

A. No. She had involuntary --

She was told just the opposite. She was told by -- her first name is Linda, I'm trying to remember her last name -- she was told by the nurse to hold on and not push before she was completely dilated.

And then she involuntarily pushed, which is sometimes -- it sometimes happens, because, you know, you get the pressure, the rectal pressure that is similar to the urge to need to defecate.

And I believe that was a cause or a contributor to her vaginal bleeding.

In fact, Linda, the day nurse, was so concerned, that we ordered an ultrasound to make sure that although this patient at one time was thought to have a low lying placenta, that the placenta might have been the source of bleeding while she was still pregnant with the baby inside.

But that ultrasound showed that the placenta was posterior. So that the increased amount of vaginal breeding that came on acutely was not related to the placenta whatsoever nor was it related to the artificial rupture of membranes, which I performed, because -- I only inserted the amnihook far enough to reach the fetal head. It never went into the body or the lower uterine segment of the uterus. It went in very, very -- you know, less than a maybe a half a centimeter past the cervix.

Q. Where did the lacerations to the cervix come from?

A. The mother pushing the baby out through an incompletely dilated cervix.

Q. Okay. So it wasn't --

So did she start to bleed prior to delivery?

A. She had some bleeding that was prior to

delivery related to when she was involuntarily -- I'm going to say involuntarily pushing, to give her the benefit of the thought.

Either she intended to push, when being instructed not to, or involuntarily pushed, which I believe -- I tend to believe is more common.

Q. Is there a note to that affect that you've read?

A. No. No.

Q. It's something you remember?

A. Yes. I remember --

Q. There's not a single nursing note that says that this lady was pushing involuntarily or voluntarily prior to the time she was instructed to push, is there?

A. And that's why we're doing a deposition today, so that I can fill in the blanks.

I certainly don't expect a nurse to spend every minute --

You know, maybe we could start video recording patients the whole time they're in labor.

Q. We don't need to do that, Doctor, because we have an almost minute by minute medical electronic record, the complete episode record, before she was delivered almost minute by minute

that the nurses note maternal heart rate, contractions, all these other things, including when you were there trying to rupture the membranes with an amnihook, including when she did start to push pursuant to the nurse's instruction, after she was crowning. That's all in the record. And there's -- you know, there are literally hundreds of documentations in the record by the nurse.

There's not a single one that says that this lady was pushing when she wasn't supposed to be pushing; correct?

A. My testimony stands.

Q. That's not what I asked.

Am I correct, sir, that there's not -- out of the hundreds of nursing notes notations on this record there's not a single one that says that she was pushing before she was told to push; correct?

A. The documentation is limited in terms of the capacity of the nurse to meet all of her obligations.

Q. Yes, Doctor. You've done this a lot as an expert witness. We have your depositions. And I know how it works with expert witnesses trying not to directly answer a question.

I'm going to ask you to do that.

Is there a documentation -- out of the hundreds of documentations by the nurse prior to birth is there any documentation by the nurse that this lady was pushing involuntarily or voluntarily when she wasn't supposed to, yes or no?

A. I did not see in the voluminous nursing notes that that was documented, no.

Q. Now, it was noted at 8 o'clock, 8:01, the night of delivery, just before the baby delivered, that the patient was encouraged to push with contractions, pushing effectively and decent noted.

That's the first time in the record it's noted -- and the only time, in fact, because the baby was born a couple minutes later, the only time in the nursing notes that anyone says this patient was pushing; correct?

A. That was a different nurse and a different time. But yes, that's correct.

Q. In your notes that you wrote pre and postop -- pre and post-delivery did you write anywhere that this patient was pushing inappropriately or involuntarily at any time prior to when she was ordered to push?

A. No.

Q. Did you write that there was any bleed

coming from this lady at any time pre-delivery?

A. No.

Q. Did you write that the cervical lacerations -- of which there were several; correct?

A. Yes.

Q. -- were caused by the lady pushing?

A. No.

Q. Did you write, sir, that --

Well, leave it at that.

Why didn't you write in the record, since you were faced with these complications that occurred, and you had a number of documentations that you made, what you told us today, that this lady was pushing inappropriately or involuntarily and that that was showing bleeding which led to massive uterine hemorrhage after birth and that caused several cervical tears; why is that not in the record?

A. Because in the event that I needed to explain the why, I could have an oral examination, as we're doing today, and explain what I believe was the cause of their uterine bleeding.

Q. Wouldn't you want that in the record for that reason, in case someone had to explain why this lady died, that you would have in the record a

documentation made by you or a nurse that this lady had pushed when she shouldn't have and caused cervical lacerations and uterine -- a fountain, as you put it, of bleeding? Wouldn't you want that in the record so that you could say at a deposition like this, well, see, I put it right in the record at the time?

A. It's simply not possible to record every event in anticipation of every subsequent complication.

Q. You know, I've heard that --

A. It's not possible for -- to record the totality of factors that may contribute to an adverse outcome.

Q. And I've heard that mentioned tens of thousands of times over the last 39 years that I've been doing this by experts.

But when you're talking about the cause of the bleed which led you to have to take her to surgery, we're not talking about documenting every single movement you made, but when we're talking about the cause of the lady's massively bleeding, don't you think that if that happened the way you said it would that you would make a documentation of that in the medical record?

A. If I had the ability to predict the future in advance, I certainly would have.

In this particular patient's case, the sequence of events that led ultimately to her having to have emergency surgery were documented.

Whether the cause was she pushed involuntarily and tore her self, the end result would have been the same, she would have eventually -- she failed medications, she wouldn't -- she had to have a hysterectomy to try to save her life from her own medical condition.

Q. Okay.

A. Her uterine atony was related to her blood loss related to her involuntarily pushing and tearing herself in the middle.

Q. You're saying that even before she delivered she had substantial blood loss?

A. That's not what I'm saying at all.

Q. Are you saying that?

A. I didn't say that at all.

Q. I'm asking you, are you saying that now?

A. I'm not saying that at all.

Q. Okay.

A. I'm saying that over time that laceration that she internally caused by involuntarily pushing

led to a cascade of events that led to her having to have an emergency hysterectomy.

Q. Okay. So this laceration -- this pushing that doesn't exist anywhere in the record before or after birth, this pushing that you say she was doing that lead to lacerations, where is the evidence in the record of any maternal bleeding prior to the baby's birth?

A. It's not recorded.

Q. Why not?

A. It just wasn't.

Q. Should it be by the nurses who are doing these minute by minutes notes?

The mother is bleeding vaginally. Shouldn't that be something you're aware of and that the nurses make a note of?

A. Well, again, what happened in this case, as you know, there was an ultrasound that was performed during the labor process because of the concern of the bleeding. The indication for that ultrasound didn't specifically address what it was that caused the bleeding.

In fact, you had asked me what do you think might have been the cause of the bleeding, and I'm -- I gave you my answer. I think she pushed

prematurely involuntarily maybe.

Q. The order for the ultrasound, did it say because of maternal bleeding?

A. I don't recall the exact -- what Nurse Chesney wrote down as the indication.

Q. If I would tell you that the nurse on a number of occasions wrote bleeding none or zero, would that surprise you?

A. It would, because Nurse Chesney called me out and asked me about the patient's placental location.

Q. Right.

Well, that's --

A. And I explained to her it was not known to be persistently low lying, although at one time it was of interest.

Let me see if I can find the ultrasound -- the official ultrasound report.

Q. By the way -- while you're doing that -- were you able to rupture the membranes with the amnihook on your first attempt?

A. I thought I had. But I thought the head was so well applied to the cervix that no free fluid was released.

Q. Nurse Chesney documented at 8:51 in the

morning on the 25th that -- sorry.

At 10:26 Nurse Chesney noted, "Dr. Lopez at bedside. Examines patient. Attempts to rupture, unable to. Blood clots present."

A. And that was the basis for the concern that the patient had been pushing and thus internally tearing a portion of the lower uterine segment.

Q. If she was tearing the lower portion of the uterine segment by pushing, wouldn't that lead you to suggest a Cesarean section?

A. No.

Q. So you wouldn't wind up with a massive bleed?

A. No.

The quantity of bleeding that was noted did not appear to be massive at that time.

Q. How was she bleeding from the uterus --

A. Inside.

Q. Excuse me.

How was she bleeding from the uterus --

If the bag of waters had not ruptured yet, how did you know she was bleeding inside the uterus?

A. The blood was coming out.

Q. Coming out from where?

A. The vagina.

Q. But she --

A. Around the cervix.

It's a liquid.

Q. Yes, I know what --

A. It comes around the cervix as a liquid and forms a clot and then come out through the vagina.

Q. And when you tried to rupture the membranes and you couldn't do so, you made no note of that, of any bleed, did you?

A. No.

Q. I'm not talking about a clot. I'm talking about a bleed.

A. No, I did not.

Q. And afterwards, when you did your post-delivery note and your postop note after the hysterectomy, you never mentioned anything about that, did you?

A. No.

But it is noted in the pathology report where they found on the cervix -- I should say the lower uterine segment, an increase in the vascularity proximal to the area of excision. And that's what leads me to the conclusion that this was the basis for which this patient had a bleed that

was probably caused by injury to the internal part of the uterus, most likely from improper pushing prior to being completely dilated.

Q. You were going to look at the ultrasound report, sir. I'll let you do that.

A. Here we go.

Well, it's --

Q. Okay.

A. It seems to be -- it seems to say evaluate placental position and fetal position. This was on page 1049. It does not mention the bleeding.

Q. No, it doesn't.

A. But the indication was, in fact, for bleeding.

Q. Doctor, when you place an order, if you felt that the indication for the ultrasound was bleeding, that's what you would order, you would say indication for procedure, bleeding, suspected bleeding; right?

A. It depends. Because of the electronic medical record, sometimes the drop down menu items -- if you're going to get an ultrasound, many times what you pick doesn't necessarily much matter, because the procedure for the ultrasound is going to be the same whether it's done for bleeding or fetal

position or placental position.

Q. But you had the ability --

A. I am not sure vaginal bleeding was an option.

Q. Really?

There's no "other" on the take down thing?

A. I don't recall.

Q. No?

But you put nowhere when you ordered this -- it was not for bleeding, as it says here, it was to evaluate the placental position and the fetal position. Nothing about bleeding; correct?

A. It's not indicated in the order; correct.

Q. Let me read specifically. Where it says ultrasound -- obstetrical ultrasound History: Evaluate placental position and fetal position.

Nothing about bleeding; correct?

A. Correct.

Q. And in the ultrasound they saw no evidence of bleeding, did they?

A. They don't record any evidence of bleeding.

Q. You certainly suspect if they saw bleeding that they would record that, wouldn't you?

A. Well, it depends on the amount of

bleeding, because you have to have a sufficient amount of blood such that you could see bleeding.

Now, as I mentioned before, the bleeding was actually being released through the cervix into the vagina.

Q. It wasn't measured, was it?

A. No.

Q. Why not?

A. It wasn't a hemorrhage at the time. At 10:22 in the morning, it was -- it could have been bleeding from the cervix dilating. That happens. And sometimes that happens before labor comes on and we call it bloody show. But it seemed heavier than bloody show, but not enough to cause me concern, other than to order the ultrasound.

I don't know if you've taken Nurse Chesney's deposition yet, but --

Q. Not yet.

A. Excuse me?

Q. Not yet.

A. Then you can ask her whether or not that was the indication, whether she's in agreement with what I'm telling you now or not.

If she didn't record it, maybe you can criticize her.

Q. Or maybe she's going to say that it wasn't bleeding.

A. You can criticize her for not checking the correct box, because the person who actually checked the box was her, not me. I gave it as a verbal order.

Q. And would you criticize her for not noting in the record that the patient was bleeding?

A. Yes.

Q. And there is no notation of it, but you say she was?

A. I saw it. Sure.

That's why we do depositions, is so that you can get the information that isn't recorded.

Like I said, it would be quite --

Q. But there's no --

A. Sir, if you keep interrupting me while I answering the question, we can terminate today's deposition and take it up before the judge.

Q. If you'd answer my question directly, it may be easier and quicker.

A. Interrupting my answer?

Q. Go ahead, sir. Answer whatever you want.

A. I'm asking you politely with respect. We're still in Palm Beach County and the rules of

conduct apply.

Q. Certainly.

A. You have to allow me to answer my question -- answer a question you pose.

Q. See, doctor, as an expert witness, that you've done many, many, many times, I know that you try to talk around an answer and you try not to give a direct answer when you don't want to.

What I'm asking you to do today -- and I will give you the chance to respond to any question with a yes or no, and then you can explain it -- but you are also required to give me a direct answer to a direct question first. And I'm asking you to do that.

In some of the recent answers you have not done that, as I perceive it.

And so I'll abide by your request to allow you to answer, if you abide by my request to please answer my question.

A. You have my full cooperation.

Q. Okay. So the baby was delivered at 8:03 p.m. on the evening of the 25th, and the baby was fine.

There was oxytocin given routinely, I imagine, two minutes later; correct?

A. Yes.

Q. And at 2:09 -- 2:06 there's something about alarm acknowledged.

Do you know what that means?

A. No.

Q. And then at -- when I said two, I meant 2006.

At 2009 or 8:09 p.m. it says Remarks: Hemabate given per M.D.

Now, Hemabate is what?

A. It's a medication -- it's a prostaglandin. It's used to make the uterus contract down firmer after the birth of a child.

Q. And oxytocin does the same thing; correct?

A. Yes, sir.

Q. And the Hemabate was, in fact, given at 8:09.

And what was the indication for that in this case?

Is that normally given or was it an indication that she was already bleeding?

A. She's already bleeding. Bleeding more than would be expected after a delivery.

Now, after the delivery I inspected the placenta and saw that it was, in fact, intact; in

other words, it was not missing cotyledons or portions of it. The membranes were also all there. And the umbilical cord was all there.

Now, I did not document that. But that happened immediately upon the release of the placenta.

And we saw -- I saw that the amount of bleeding was more than the usual amount, even though she was receiving uterine massage and oxytocin through her -- in the usual quantity through an IV line, I ordered and administered Hemabate.

Q. Where did you think that bleeding was coming from?

A. At that point it appeared to be coming from inside the uterus.

Q. And if it's inside the uterus as opposed to the cervix --

The uterus is above the cervix; right?

A. Yes.

Q. Goes into the cervix?

A. Correct.

Q. If it's coming from the uterus, you're attempting --

The uterus is a muscle; right?

A. Yes.

Q. And atony means that it's not contracting the way you would expect it to be?

A. Correct.

Q. So that's why you gave Hemabate and oxytocin, to see if that would stop the bleeding from the uterus?

A. In addition to uterine massage.

That's correct.

Q. Okay. Now, you also were performing at 8:10, a minute after the Hemabate, performing cervical laceration repairs.

Did you note bleeding from the cervical lacerations?

A. Not that much.

And that's what was one of the causes of concern.

As I was doing the cervical laceration repair, I requested something called mini laparotomy packs. And what those are -- it's gauze, surgical gauze about, I'm going to say, an inch and a half by about 6" long, with a blue tag at the end of it. So when I concluded the repairs of multiple lacerations of the cervix.

And, again, those lacerations of the cervix are common when a patient has pushed before

complete dilation of the cervix; in other words, the cervix isn't completely gone from the baby's head. If you push, the forces can tear the cervix.

And I actually tamponaded the lower uterine segment with a mini laparotomy pad, and the -- there was no bleeding from outside of the mini laparotomy packed tampon. And the mini laparotomy tampon became saturated with blood.

In fact, I used several of him serially.

Q. Twenty-five, actually.

A. I had them weighed to get an estimate of how much blood was coming through -- from the inside of the uterus, not the outside of the uterus.

Q. If she was bleeding from the uterus -- Well, strike that.

If she was bleeding from the cervix as a result of this undocumented pushing that you say happened, that bleeding would have been taking place throughout the remainder of her pregnancy, before the baby was born, from the time she started pushing to the time that you delivered the baby and even thereafter?

A. I'm not sure I understand your question, sir.

Q. How did the baby -- how did the pushing

lacerate -- the word laceration seems to be -- Isn't that a cut, a laceration?

A. There's several different ways that it can happen.

Q. As opposed to a rupture, in other words.

A. Yes.

We can argue it one way or the other whether it was a cut, a laceration or a tear.

If we were to say that as the head comes through the cervix -- the cervix generally, which is kind of rubbery, it's muscle and fibrous connective tissue, will expand to a point. If the pressure exceeds the strength of that muscle connective tissue portion of the cervix, if -- you'll get -- you'll get a tear or a laceration.

And a laceration is a nonsurgical cut, tear, rip that can cause bleeding.

Q. At what stage of the head decent -- What actually causes the laceration, is what I'm getting at?

If the head is not yet coming through the civics, how does this laceration occur?

A. It happens because the elasticity of the cervix --

It's like a rubber band. If you go beyond

a certain round area of space and exceed the ability of the elasticity of the rubber band, the rubber band will break, rupture or tear and tear open.

If the patient pushes before the cervix is completely off the head, then the cervix will tear. It will tear because the force of -- the propulsatile force of the baby's head coming through the cervix, not completely dilated, is like a force greater than that tensile strength, the strength of a rubber band to stay intact, and a laceration or a tear will occur.

Q. But --

A. In that regard --

Let me also say this, please. Blood vessels that form on the inside of the lower uterine segment, like were noted on pathology report of the portion of the lower uterine segment that was removed, notes that some of those blood vessels were large and dilated. And that would be higher up than the cervix. Which, as you know, I left the cervix in. I didn't remove the cervix.

Q. How do you know that?

A. Because I knew, having examined the patient with my own eyes, even though I didn't record it, that there was no bleeding coming from

the cervical lacerations. That was not the source of this woman's hemorrhage. It was internal to that and superior to that, by a process of deduction.

When I put the mini laparotomy tampons and there was no bleeding from where the suturing up had occurred, that wasn't the cause of a postpartum bleed. It had to be higher up.

And that's why that technique is used. You tamponade the cervix. And if the bleeding is coming north of the cervix, it's not the cervix that's causing the postpartum bleed and relieving --

Q. Why --

A. Excuse me. Let me finish.

Q. Well, it's going on a little bit, Doctor. More than I asked you.

A. I apologize for that, sir.

Go ahead.

May I ask a question?

Could I take a one minute break to get a little more coffee?

Q. Sure.

(Whereupon, a short break was taken.)

BY MR. COHEN:

Q. Now, Doctor, according to the medical record, while you were attempting to repair the

cervical lacerations, they -- there was another 30 units of oxytocin given at 2020 or 8:20, and there was another dose given at what looks -- I don't know if that's the same note or not, so I'll leave that alone. But it does say at 8:30, "M.D. remains at bedside. Performed cervical laceration repairs."

How many lacerations were there of the cervix, do you know?

A. I believe in total there were three.

And that's the other thing that kind of led me to believe that she had pushed before the cervix was completely dilated, because the location of these lacerations -- one would have been at about 10 o'clock, the other one would have been on the face of a clock, I'm going say, probably around 2 o'clock, and then the other one towards the bottom would have been around say 7 o'clock.

And that stellate pattern is somewhat typical of when a head goes through a cervix that's not completely dilated. It tears kind of in quadrants.

But in this case there were only three. And they were repaired to the point where there was no blood coming after, you know, I tamponaded the

end -- the uterine entrance.

Q. You wrote a progress note. It says here -- it's timed at 8:10 into the postpartum note. I'm just going to hand it to you.

A. Thank you.

Q. Can you read that note to us.

A. "Postpartum hemorrhage treated with IV Pitocin, Hemabate IM times one, Cytotec rectally 1000 micrograms. Massage. Second IV line placed. Anesthesia, nursing supervisor called. Recommend hysterectomy."

Q. Okay. So there's no mention in that note that she had any pre-delivery bleeding or that she had pushed in a way that caused lacerations or hemorrhage, is there?

A. No.

Q. And you certainly could have put that in there if you chose to?

A. If I had the ability to know in the future that litigation would ensue, certainly.

Q. No, sir.

If that's what had happened, wouldn't you have written in your note something that important, that she had been pushing against somebody's rules and that she had lacerated her cervix and possibly

uterine bleeding because of pushing?

Wouldn't you make a note of that?

This is not a drop down menu. This a handwritten note.

A. Right.

And the answer to that is, again, if I had the ability to have foresight, yes, in this case.

If I did that -- if I wrote that in every single case that it happened, then it maybe would have made me a better documenter.

But as a trained surgeon, as a trained gynecologic surgeon, my notes have always tended to be brief and maybe not as comprehensive as nurse's notes.

Q. And the nurse's notes, as we said, don't mention any of that, either. The very comprehensive nursing notes don't mention anything about bleeding in any way prior to the delivery of the baby; correct?

A. That's right.

Q. Okay. The charge nurse, Miss Shanken, was called to the bedside at 8:30 for additional assistance.

And at 8:45 p.m. it says, "The patient remains moderate lochia flow, fundal massage

performed by M.D. Large gush blood noted with clots. Fundus firm after massage."

Tell me what that means.

A. What that means was, what was happening was, there was some periods of time where the amount of bleeding diminished as if it was going to stop or become what we would consider an appropriate amount or an acceptable amount of bleeding, and then it would crescendo, meaning the volume would increase acutely. And -- with fundal rubbing the whole time, okay, after all the lacerations repaired, the cervical as well as the vaginal laceration was repaired, there would be a crescendoing, meaning a spike in bleeding and then it would stop, it would slow down. So it was like a spasming blood vessel on the inside of the uterus was the cause.

And that's the thought process that I had, that this is the type of bleeding that since it's failed Pitocin, it's failed more Pitocin, it's failed methargen -- I'm sorry -- Hemabate, and it's failed Cytotec, which is, you know, another medicine, so essentially three medications, physical massage, surgical repair of what is visible, what I can see. What I can't see is what is going on inside the uterus. But what I can see is the

quantity of blood. And, again, it fits a pattern of crescendoing, then de-crescendoing, crescendoing, de-crescendoing. There were times when we thought we had this thing stopped. The uterus had contracted down like it was supposed to.

Q. Okay.

A. But then we recognized that that wasn't the case at all. Her vital signed changed. We ordered blood testing and blood work; meaning, CBC. And I ordered, in addition, two units of packed red blood cells. At the same time I asked for the nursing supervisor and other parts of the supporting team, including at one time a rapid response team to come to the room, the anesthesiologist to come to the room, because it appeared that all of our conservative measures of stopping this postpartum bleed were failing and we were going to have to go to the next level.

Q. At 8:45 there's the note I just read from the nurse about the large gush of blood noted, fundal -- fundus firm after massage.

Also at 8:45 it says the maternal blood pressure was now 95/58.

That was a drop from what it had earlier been; correct?

A. Yes.

Q. Did that give you evidence that the patient was losing blood?

A. Yes.

And that's why we asked the nursing supervisor to get an operating room ready.

Q. And that was at 8:45.

And then her maternal heartbeat was at 128.

That's high, isn't it?

A. Yes.

It's gone up. It went up. It's accelerating.

Q. Trying to compensate for the loss of blood pressure?

A. Yes, sir.

But by that time blood had been ordered from the blood bank.

Q. Now, blood wasn't given to this patient until in surgery later on; correct?

A. That's right.

There was definitively -- you know, if I had a couple of criticisms, my first criticism is that the blood banking was exceptionally slow, as was getting the results of her blood work that was

ordered in an emergency situation. Her blood work was ordered stat as was the blood that was supposed to be getting ready to be crossed. It was not given -- it was not available to be given even after the anesthesiologist came, Dr. Duclas, and ordered four more units of untyped uncrossed blood. Blood did not come for a white. And for that I fault Good Sam and their blood banking unit.

Q. All right.

A. And their laboratory.

Q. If it had come when you ordered it on the time basis you would have expected it, you would have started it earlier?

A. Absolutely. We would have given the blood immediately. Yes.

Because once she became tachycardic, we all knew she needed blood, when I say all, the nurse and I, the nursing supervisor.

In fact, we spoke fairly curtly about we need to get blood bank -- somebody call blood bank.

My impression, and I can't -- again, this investigation is not done by a long stretch -- maybe they were shorthand.

The phlebotomist took awhile to get down to draw the blood to begin with. It took a while to

get the blood to begin --

We were already doing surgery by the time the blood arrived.

And that's wrong. That blood should have -- this is a special care unit. Blood should have been available much more quickly than it was.

Q. Do you think if it had been that this lady had a better probability of surviving?

A. Yes, sir. Depending on what you wish to believe how much of the --

You know, the pathologist wrote a report. Like I said, I have some concerns over.

And, again, both sides get to say -- get to have somebody look at it.

If we were able to have gotten the blood more timely, I believe she would be alive today.

Q. Okay.

A. And if we were able to have gotten blood in a timely way, I truly believe Miss Lopez Castillo would be alive today.

Q. Okay.

A. Castillo-Lopez. I'm sorry.

Q. That's okay.

So at 8:57 -- now, this is about 55, 54 minutes after the baby was delivered -- her maternal

blood pressure, the mom's blood pressure, was 66/45.

So it had dropped substantially; correct?

A. Yes.

Q. And her heart rate had risen to 136, it looks like, at the same time; meaning, that her heart was beating faster to try to compensate for lack of blood pressure because the blood volume was dropping?

A. Correct.

Q. And when somebody's blood pressure is down that low and their heart rate is speeding up to compensate for it and there's a loss of blood volume --

There was a substantial loss of blood volume at that point; correct?

A. Yes.

Q. Enough to effect her vital signs in this way?

A. Correct.

Q. Okay. Do these numbers indicate that she's going into shock?

A. Yes.

Q. Okay. Would you agree that with reasonable probability at this point she was in shock?

A. Yes.

Q. Secondary to blood loss?

A. Correct.

Q. And then at 2100 hours, which is 9 o'clock, it has a quantitative blood loss obtained through 20 soaked mini pads 526 grams.

What does that mean?

A. Well, that was documentation by the weight of the laparotomy packs. In other words, they took all the ones that had blood in it, and then they weighed one that didn't have blood on it, so that we knew that beyond any doubt that we were dealing with a postpartum hemorrhage by every definition in the book.

Q. Okay.

A. Okay. We already knew that clinically.

That was a documentary -- this is one of those things to make you happy that you didn't document, you didn't say -- you said this, but you didn't write it down. Now, we wrote it down.

We already knew what the problem was.

The problem was --

We already ordered blood.

The problem was, the blood bank wasn't bringing in a way that we were going to be able to

resuscitate this woman before we had to go back to the OR.

Q. And she was continuously bleeding at this time?

A. Correct.

But we were massaging. I was at the bedside, I was there. The nurse was there.

Q. But the Hemabate and the oxytocin were not stopping the bleeding?

A. Correct.

And there's time limits as to how often you can give them. You know, the Hemabate, I think, like 20, 30 minutes is typical. The Pitocin was going -- the lower dose of Pitocin was what she started out with. Then we added more Pitocin to give her a higher dose.

This was not -- her uterus was also in shock. It wasn't just the mother, it was her uterus.

And what I mean by shock is, it's not responding in a typical manner because it's blood deprived.

Q. So it's completely atonic?

A. I wouldn't say 100 percent atonic. But it was more atonic than it wasn't.

Sometimes it would respond just a tiny bit; again, crescendoing, de-crescendoing, in terms of the amount of blood that would pop out. The uterus would have moments where it was firming a little bit, but it wasn't stopping. We knew she was going to be having to go to the OR.

Q. And that was my next question.

By 8:45, when you were -- you know, the large gush of blood was happening and the vital signs were dropping, had you already made the decision that this lady needed to go back to -- to go to surgery?

A. Yes.

Q. At about 8:45?

A. Correct.

Actually, one other thing happened that wasn't documented, I asked for something called the postpartum hemorrhage cart.

The postpartum hemorrhage cart is a -- it's like a red Craftsman tool cart that usually contains things like a -- something called the Bakri balloon, which is like a tube that you can fill with saline to put inside the uterus to cause mechanical distention. It also usually will contain medications such as methargen, which would have had

to be requested from either the Pyxis or downstairs from the pharmacy. It would have the ability to have a large quantity of not the mini laparotomy packs but the large packs, in case I wanted to pack the uterus with laparotomy packs.

These are all mechanical ways of stopping internal uterine bleeding.

They didn't have one. I asked for one. It didn't exist.

Q. Okay. Again, you already said, I think, that that was not noted anywhere in the record?

A. It's not noted.

Q. But that's what you remember?

A. That's correct.

Q. And that would not be within the standard of care for the hospital to not have that available, would it?

A. Among other things.

Yes. That's correct.

Q. The order date --

Have you looked to see when the actual blood was ordered for the first time?

First -- let me ask first, did you order the blood or did Dr. Duclas or somebody else order the blood?

A. I was the first person to order blood.

Q. Okay.

A. I was also the person that asked and called for Dr. Duclas to respond.

Q. Okay.

A. Who was the anesthesiologist who was on call.

I knew that because the patient during the time we did cervical repairs had a active epidural going.

Q. Right.

Do you know, sir, when the first request for a blood -- for blood products to come up to this lady's bedside was?

A. I don't recall the time. It is recorded in the blood requisition slip.

Q. Right.

And the first time I have is 2122, which would be 9:22, which is over an hour after she started bleeding or was noted that she started bleeding.

You think it was earlier than that?

A. Of course it was, for the following reasons: They use an electronic medical ordering record at Good Sam, so in order for the order to go

to the blood bank, in today's world a nurse has to go in front of a computer, log in, put in her log, go through the panels until -- what I mean by panels is, each screen shot, you've got to go to the blood banking screen shot, you would have to check packed red blood cells, have to type in probably everything .

-- if you would tell me what page you saw that, the time on it, I'll tell you everything she has to type in, which is more than a few things.

Q. On the --

A. It's not that relevant.

What I'm going to tell you is, they have to fill in a series of pages -- not pages, but lines on that screen shot before the order gets fired off electronically to the lab.

Q. Okay. Is there something --

A. To the blood bank. I'm sorry.

Q. Was there something that was called a massive hemorrhage protocol at Good Sam at the time?

A. Yes. I believe it existed.

Q. Okay. And it's something that you were aware of at the time?

A. I was.

Q. Did you institute that protocol?

A. No. And I'll tell you why; when Dr. Duclas came into the room, he ordered the massive blood transfusion protocol.

And, in addition --

I've known Dr. Duclas. He's an excellent anesthesiologist, also an intensivist of sorts, has training in taking care of very sick post-hemorrhage patients.

He asked to institute the massive transfusion protocol.

Q. Is that noted anywhere in the record, that anybody instituted the massive transfusion protocol?

A. I never saw it, no.

Now, this is --

Q. Tell us what it is.

A. Well, there's a number of -- it is an order device whereby the order set, which would consist of -- if you order four units, you get four plus two units of blood. You get whatever amount of blood you ordered plus more on an ongoing basis.

What it is in a global sense is, it sends the signal to the blood bank all hands on deck to get lots of blood available. Okay. There's a bleeding emergency in progress.

It usually will include certain clotting

factors, it will automatically include platelets, it will automatically include red blood cells, it will automatically -- like I said, it would automatically include fresh frozen plasma, platelets, red blood cells, and I think Factor VII, in most hospitals.

I have seen it implemented while I was walking through the operating room hallways when a vascular case would be going on. A nurse would run out of the room and go "we need to implement the massive bleeding protocol."

Q. Okay.

A. Okay. Now, unfortunately, another criticism I kind of have of the hospital is, they never did the periodic drills for postpartum hemorrhage ever. And I've been there 30 years until I wasn't there. And then I think there was a period of time when they closed OB that I wasn't there as well.

So I'm not exactly sure that the nurses on L and D understood what he was talking about, because it's not something that's commonly ordered on L and D.

I'm sure everyone understood, he said four units of packed -- four units of cells unpacked uncrossed stat. And that's the second order you'll

see in the blood bank sequence.

And again, to get even to that page involves a nurse to log in, type in, there may be three or four screen shots that have to be completed accurately or the order doesn't fire.

Q. So standard of care would have required that somebody, whether it was you or Dr. Duclas, order the -- institute the massive hemorrhage protocol?

A. Right.

Massive transfusion is what we call it.

Q. Which is what this patient was needing?

A. Correct.

Q. What was needed for this patient. Excuse me.

A. Yes.

Q. And one of the things that you mentioned correctly, I believe, in the protocol is for platelets are ordered as well as packed red blood cells and other things, platelets get ordered?

A. Correct.

Q. Did this lady ever receive platelets?

A. No.

Q. Why not?

A. Well, I'm going to conjecture that the

reason why not may have been, when Dr. Duclas asked for the massive transfusion protocol, I believe he was under the assumption that, number one, it existed, number two, that platelets were going to be coming in the ratio that is generally used, platelets, fresh frozen plasma and packed red blood cells.

When you mix those three things in a cocktail, that's what whole blood is. Whole blood has red blood cells, fresh frozen plasma and platelets.

Q. Right.

A. That's why -- you know, it's like splitters and groupers. Okay. Splitters is when you would order just platelets, just fresh frozen plasma, just red blood cells.

What we were looking for was that whole package.

Like a car with tires, a steering wheel, a stereo, and in Florida an air conditioner. That's a car. Okay.

He was expecting all of that to come as a package, and it didn't come. It came -- what did come came late, came slow.

He had the manpower. He had another

anesthesiologist that was there.

Q. Dr. Brown?

A. Right.

I mean, it's like the thing -- the element that we didn't have in a timely way was the life saving components of massive transfusion.

Q. Okay. And as of 8:45 that's what she needed?

A. Correct.

Q. Okay. And all the way to the end did she get it?

A. Never got platelets. I'm not sure that she got the right amount --

In fact, when she went to the ICU I was also surprised that she didn't get what she needed even then.

Q. Okay.

A. And that is -- when I mean unit, I'm talking about -- She was taking an MICU, medical ICU.

Q. And do you know whose job is it at that point to see that she's getting the proper blood products, including platelets and red blood cells and even Factor VII, if necessary?

MR. MIDWALL: Object to the form.

A. In a general way it would be the intensivist in combination with Dr. Duclas and perhaps Dr. Brown, the three people who have ICU privileges.

I do not have intensive care unit privileges at Good Sam. My orders would be moot. I'm not sure they would take an order from me, because in my credentialing package when I applied for privileges at Good Sam, I do not have ICU privileges. It's a whole separate package that you have to fill out.

I have basic OB/GYN abilities. My powers stop there. My knowledge base ends.

There are people that have much more extensive knowledge in blood resuscitation than I do, and two of them were there during our surgery and a third one was there when she went to the ICU.

BY MR. COHEN:

Q. Okay. Did you ever come to -- did you ever find out or get knowledge as to why this lady never got platelets, never got the proper amount of blood products that you mentioned she needed?

MR. MIDWALL: Form.

A. Let me answer it this way: I was immediately shut down with a finger pointing towards

myself and the other OB/GYN. That's all -- I think there was a political decision made by whoever to circle around and to lay the responsibility -- you know, to bring in the usual suspects. Since this was an OB case, therefore it's an OB problem gone wrong, rather than --

And, again, that's part of the reason why when you're going to go before a review -- a serious review of a mortality, it's very critical that the members of the review be independent, be different than the ones that are politically active within the hospital, and can honestly and accurately note all the things that may have caused or contributed to this terrible outcome.

So when I started to ask, I was shut down by the hospital -- by people in the hospital, in terms of administrators, in terms of other people. So I could not get an answer to my questions.

BY MR. COHEN:

Q. But the -- for whatever reason that you couldn't get answers to, you'll agree that she did not get the type of blood product replacement that she needed?

MR. MIDWALL: Form.

A. She didn't get it. She didn't get it

timely.

I'm not sure that all the elements to provide that level of care were even available at that time; in other words, if the order -- if the electronic order grouping for massive transfusion policy didn't exist at that time.

Because, again, subsequently I was cut out from being able to do my own independent investigation as to why it didn't happen.

BY MR. COHEN:

Q. Okay. What I was referring to is that we know she never got platelets. And you said earlier she didn't get -- you were concerned that she didn't get enough blood after she was in the ICU. And you don't know why. You were cut out.

But can we agree that she didn't get sufficient replacement?

A. Absolutely not. Yes, I absolutely agree with that. She wasn't even close.

Q. Okay.

A. And those are the types of things that you would expect the hospital to have had, since they run an OB unit and things can -- blood can be very critical not only in OB but in other areas, but certainly in obstetrics.

And this was an example where all those elements needed to be there well in advance of Miss Castillo-Lopez coming there.

Q. Okay. Because these are things that can be anticipated for many patients under different circumstances?

A. Correct.

Q. Did you know that the intensive care doctors that would cover the intensive care facility at certain times of the day were actually by tele view or tele doc, what they call Nuview in this case, which means that they're someplace else and they appear by computer?

A. I found out later. I knew --

Q. Okay.

A. Because I've had other patients that have been transferred to the ICU.

Q. And, in fact, the doctor in this case that was finally called about midnight, a little after midnight, was actually in Jacksonville when he was called.

A. I did not know he was in Jacksonville.

Q. Okay. We'll get to that later.

So we knew as of 8:45 that she needed surgery and she needed various blood products that

she wasn't getting. And -- but she's not moved to the operating room yet.

As of 12 -- excuse me -- as of 9:18 her blood pressure now is 72/33, and then a minute later it's 78/51, and her O2 -- her SPO2 is 83 percent.

Indicating to you that she's, again, in shock and not getting proper blood volume?

A. Correct.

Q. Not getting proper blood volume.

Not having proper blood volume?

A. Correct.

She's having a hemorrhage in a more serious stage, where now hypoxia is an issue. She doesn't have enough red blood cells to carry oxygen to all the vital organs, and almost certainly heading into acidosis because of the lack of red blood cells to carry the oxygen to the tissues of her body.

Q. Now, according to the record that I have -- that we have, the first order for a stat CBC was at 9:15, which is over an hour after she was noted to have been bleeding post-delivery.

Do you dispute that time as being the first stat order for a CBC?

A. That would be the time that it was

entered.

The order could have come before that, because, as I mentioned, the orders -- you know, in the telephonic era, which is how we used to do things in the old days, you would pick up the phone and make a phone call.

Q. Right.

A. In the electronic medical record era you have to have, in this case, a nurse be able to go to an open computer, open up, put her codes and her, you know, criteria -- credentials and codes in, wait for the screen to come up, go to the lab ordering section, pick the lab, pick the indication, and then allow it to be sent out electronically.

Q. Okay.

A. And the time may have been 9:15 it was entered --

Q. According to -- I don't mean to cut you off.

Just so you know, according to the lab sheet it says collected at 2115.

A. Okay. But the order would have taken a period of time to put in, because now, again, you have to go through multiple screens to get to the blood order. And then it takes a period of time for

the phlebotomist, if they were adequately staffed, and understanding that labor delivery unit is a special care unit, it is not an operating room, it's a special care unit that has the highest level of priority in the hospital.

Q. I want to --

Before I read the lab results.

The night before there was a routine CBC done which showed her hemoglobin was at 10.3 and hematocrit at 32.

For a pregnant woman is that about right?

A. Common. That's common.

There's a mild anemia of pregnancy that is almost universal. It would be rare to -- in my practice to see a patient with a hematocrit higher than 35. I don't think I've seen it --

Q. Okay.

A. This would be a typical --

And her platelets were normal.

Q. Right.

A. Which, I believe, is also typical, because there's a physiologic hemodilution during pregnancy where their total blood fluid level goes up about 40 percent in pregnancy.

Q. Okay. And now at 9:15 on the night of the

25th, again, about an hour and some minutes after she started -- after it was noted she starts bleeding, her red blood count 2.95, her hemoglobin is 7.3, and her hematocrit is 22.7.

So what do those drops tell you?

A. That's a significant drop.

And as an OB, who was physically there, the clinician, I know that that may not actually reflect the actual level of what's going on, because she had other clinical signs that indicated that her blood loss was actually greater than what that lab value meant.

And that's why the urgency to have timely blood bank and blood banking was critical, because even though the numbers were -- at 22 seem only mildly to moderately abnormal, her clinical picture was much more significantly worse than what the numbers appear to indicate.

Q. Okay. And it had dropped from 32 to 22 in the 24 hours.

So, as you said, that's an indication only to an extent of how much blood she lost, she actually probably lost more blood than that reflects; correct?

A. That's correct, for a couple reasons. One

is, we increased her IV fluids. Okay. We increased her Pitocin. And Pitocin would have an antidiuretic affect, which would tend to allow her to retain more water volume.

So the blood carrying capacity red blood cells clinically appeared to be much lower than 22, even though that's the number that was reported.

Q. What does that tell you about the percentage of blood that she's lost?

How much does the normal average human have liter of blood in their body, five, six?

A. Five to six, maybe.

Q. Okay.

A. I'm trying to remember. She wasn't a particularly tall and she wasn't fat per se.

Q. No.

A. So five to six liters.

Q. Okay.

A. She may have lost maybe half of her blood volume by that time, by her clinical parameters, not by just the lab alone.

Q. It could be two to three liters?

A. Correct.

Q. Okay. So just for demonstration purposes, I have some liters of red fluid here.

So by the time -- by 9:15 -- this is three liters. So somewhere between two and three liters of blood, and you only have five or six in your body, this much has been lost and nothing has been replaced yet; correct?

A. Correct.

Q. Okay. And, therefore, the organs of the body are not going to be adequately perfused if this goes on; correct?

A. Correct.

Q. And the patient's blood pressure, because of that drop which causes lack of perfusion to the organs of the body, and the patient's heart rate at least initially is going to attempt to go higher to try to compensate?

A. Correct.

Q. Okay. And there was no replacement of this --

And she was continuing to bleed.

This is -- if she stayed here at 9:15 --

A. She hadn't stopped yet. Correct.

Q. -- she was still going further?

So by the time you took her to surgery, which wasn't until 10 o'clock that the surgery started, actually, a little after 10 o'clock, and

then she got the blood transfusions after that, how much would you say she had lost by that point, since none had been given?

A. It was certainly more than three liters.

It would be a guess. I couldn't --

I would say she was in severe shock.

Q. Okay. All right.

Okay. So at 2118, at 9:18, almost 9:19, her blood pressure had now dropped to 55/27.

That's dangerously low, is it not?

A. Correct.

Q. Obviously shock?

A. Yes.

Q. And it stays low. 2120 -- excuse me -- a few minutes later it's 54/30. There's some more oxytocin given by bolus. And then there's a rapid response called. According to the record, the nurse noted -- Nurse Ryan Gavani noted that at 2125, 9:25, rapid response was called by Nurse Hankin.

So according to the record, the first time --

You said you ordered the rapid response, or did Dr. Duclas?

A. No. I did.

Q. Okay. So the record indicates it wasn't

ordered until 20 minutes after 9:00, when we know this started over an hour earlier.

Is that accurate?

A. I wasn't actually recording times and per se -- I would depend on the record as recorded.

Q. But you told us that about 8:45 -- by 8:45, maybe earlier, that you had already decided to take her to surgery. And we know her blood pressure was already dropping and other things by 8:45 and then it continued to get worse.

A. Correct.

Q. Why would you not --

If that's accurate, why would you not have called the rapid response prior to 9:25?

A. I had the false expectation that blood was going to arrive.

Q. Okay.

A. I had every expectation that blood products would be there.

Q. All right. It's also recorded here at 9:25 that anesthesia was notified of need to come for patient vital signs and come to assess patient.

So, again, that's, you know, an hour and 15 minutes or so after she was noticed to be bleeding heavily, and 40 minutes after you made --

at least made the decision to go to surgery according to the nursing note anesthesia was first being called. Is that -- can you --

A. That's --

Q. Can you say that that's not correct one way or the other?

A. It seems delayed. Correct.

Q. But it wasn't until anesthesia got there that you said that Dr. Duclas -- I guess --

A. Duclas.

Q. Then you say instituted the massive hemorrhage protocol, although it was never accomplished?

A. I heard him order it. He ordered four units of packed -- four units of packed uncrossed untyped cells.

The first units I had ordered maybe a half an hour earlier hadn't arrived. But the expectation was that it was coming.

Q. Okay. At 9:30 the nursing supervisor and rapid response team were at the bedside, according to this. They were called at 9:25 and they were at bedside at 9:30, according to the nursing notes.

So it indicates that --

Who was part of that rapid response team

in this case?

A. Usually it's an intensivist -- I'm sorry -- a hospitalist who's in the hospital. If the hospitalist is tied up, they would send the mid level of the hospitalist service to come and evaluate the circumstances.

They came into the room, they saw that there was a physician present, they may have written a note, and then I believe they left.

Q. Okay.

A. Because they probably also recognized that what was needed was blood and blood products. They can't create blood or blood products. They were not going to be able to advance the care of this patient.

Q. Okay. Were there any pressor agents given up to this point to try to raise the blood pressure?

A. No.

Q. And the reason for that?

A. I don't have pressor privileges.

Q. A pressor, just so the record is clear, is medications that are used to increase the blood pressure in the face of shock and loss of blood; correct?

A. Correct.

Q. And what you're telling me is that even if you had wanted to order pressors, you were not allowed to pursuant to your privilege -- the privileges you had at that hospital?

A. Correct.

Furthermore, I don't believe the nurses on labor and delivery are trained in the use of Levophed or epinephrine or any of the other pressors that are used.

Q. Then why not call immediately back, you know, an hour earlier, somebody like an anesthesiologist who would have privileges; correct?

A. Yes.

Q. Why not call somebody like that to come, or an intensivist or whatever you needed to give pressor agents?

Did you not think they were necessary?

A. I thought blood was going to be there sooner than it came. I can only imagine if I had asked --

Well, first off, the intensivist is in Jacksonville. That's about five and a half hours away.

Q. But he can order over the phone.

MR. MIDWALL: Form.

BY MR. COHEN:

Q. If he's told that the patient is massively bleeding and her blood pressure is dropping, she's in shock, and all these other things that we talked about, at some point during this hour and 15, 20 minutes, as far as you know can he order pressor agents to be given?

MR. MIDWALL: Form.

A. Yes. But he has to have nurses that are qualified, that have the knowledge, training and experience to administer those drugs. And that would have required that patient to have been transferred into one of the -- either the medical or the surgical intensive care unit.

Q. Okay.

A. I have never in my career have had knowledge of a labor and delivery nurse to have experience or training in the use of pressor agents.

If there has been an indication for a pressor agent, the patient would be moved off the floor to a special care unit like an ICU.

BY MR. COHEN:

Q. Okay.

A. This is not a cardiovascular unit. This is an OB unit.

Q. I understand.

Did the members of the rapid response team include anybody that could order a pressor agent or recommend one at least?

A. I don't know. I don't know the credentials or limitations of --

All I know is that they came, they saw, they left.

Q. When the anesthesiologist Dr. Duclas arrived, and Dr. Brown at some point, do you know if they gave a pressor agent?

A. I don't know exactly. I do not recall them giving pressor agents.

Q. Okay. According to the record that we have, at 2125, 9:25 p.m., the decision was made to OR for TAH.

TAH is?

A. Total abdominal hysterectomy.

Q. Dr. Tomaselli notified and on his way.

That's because a surgeon -- you were going to do surgery and you needed -- under the restrictions on your licensure and privileges you had to have an attending supervising doctor at bedside for an operation; correct?

A. Yes.

Q. A total abdominal hysterectomy means what?

A. The removal -- it's the surgical removal of the uterus and the cervix.

Q. Okay. Was that your plan?

A. My plan was either -- as I dictated in the note, to either perform a supracervical hysterectomy or a total abdominal hysterectomy.

Q. Okay. I'm not going to go through all the blood pressures, 59/25, 67/32.

There's a second needle placed by anesthesia at 9:30, an IV 20 gauge placed in right hand by anesthesia.

Do you know, sir, whether a 20 gauge needle is the smallest one available?

A. It's pretty close to it.

Q. Okay. Do you have any opinion as to whether a larger one should have been placed under the circumstances?

A. Absolutely. I would have expected a central line to be placed.

Q. And that was not done?

A. No.

Q. And the reason that you would expect a central line to be placed is what?

A. This patient needed massive transfusion

with large volumes of blood and other -- blood, fresh frozen plasma, platelets and fluid.

Q. And you can't do that through a 20 gauge needle effectively, can you?

A. No.

Q. And then at 2138 it says, "To OR via bed for total abdominal hysterectomy."

MR. COHEN: Anybody need a break?

(Whereupon, a short break was taken.)

BY MR. COHEN:

Q. Now, Doctor, one of the things that is done before you bring a patient like this to surgery for hysterectomy is, you have them sign a consent form; correct?

A. Yes.

Q. And, in fact, let me hand you the consent form that was signed that evening.

And do you recognize that?

A. Yes.

Q. And do you recognize your signature on that at the bottom?

A. Yes.

Q. Okay. And also either the husband or the wife, I can't tell from that, frankly, but maybe you can, signed it.

A. It was the wife.

Q. Okay. So she was still aware enough at that point to sign for consent?

A. Yes.

Q. And the consent was for a total abdominal hysterectomy, was it not?

A. Yes.

Q. It didn't say anything about a subtotal or a -- or anything less than a full hysterectomy, did it?

A. Except for line two.

Q. Which says?

A. "My physician has explained to me that sometimes during the operation it is discovered that an additional surgical procedure is needed immediately. If I need such additional surgery, I permit my physician to proceed."

And on the basis of that and my dictated note that describes that I did speak about the possibility of it being a supracervical versus a total.

That covers the fact that it turned into a supracervical, because in general the principle is, you want to control the bleeding maximally as soon as possible. And if that means you have to do a

supracervical rather than a total -- and recognizing that I already knew it wasn't a cervical bleed, because I'd done the things we've already talked about -- that that's why -- even though it may say total abdominal hysterectomy, in fact, I had permission to proceed with a supracervical as well.

Q. Well, to be accurate, as you just read it, you explained there may be additional surgery necessary, but not less than abdominal hysterectomy.

In other words, you didn't explain -- on the consent form it doesn't say possible supracervical or total abdominal. It says -- the only thing it says is total abdominal and you might need to do more surgery.

A. And, in fact, when you do a supracervical surgery, it is more surgery. Because what you have to do is, you have to oversew the top of the cervix. And that's not less surgery. That's more surgery.

I know it sounds confusing.

Total only mean uterus plus cervix.

Supracervical means you leave the cervix. But you actually -- it takes more time and you do more operating when you do a supracervical than when you do -- you know, when you remove the cervix.

When you remove the cervix, you just have

to sew up the vaginal cuff.

When you do a cervical supracervical, you have to sew up the cuff plus the top of the cervix to establish hemostasis.

And, as I mentioned before, the procedure I did also ablated that lower uterine segment portion which I had suspected was the cause of the bleeding.

And the reason we did it that way is so that by direct visual observation I saw that there was no further bleeding from that little piece of lower uterine segment nor from the top of the cervix that would have explained why she bled despite the medication, the massage and so forth.

So with all due respect, sometimes the word total really messes people's mind up because they think total means more and subtotal means less.

Q. Okay. So you went into surgery.

And Dr. Tomaselli was he there by the time the surgery started?

A. Yes.

Q. Okay. And did you discuss the case with Dr. Tomaselli, as to what had happened leading up to this and what you felt was going on at that time?

A. Yes.

Q. And did Dr. Tomaselli agree that she needed to be taken to surgery immediately?

A. Yes.

Q. Okay. Now, the anesthesia time is a little difficult to read on this record, on the anesthesia record. It says the anesthesia time is at 2140. But the start of the surgery says something like 2201, meaning 10:01, and it ended at 11 o'clock.

Again, if accurate do you know why she didn't -- that it was almost two hours from the time she started bleeding to the time you started operating, while she was massively bleeding, in shock?

A. No, I do not.

Q. Okay. Is that acceptable to you?

A. I have no opinion one way or the other.

Q. Okay. Do you think something held you up, or do you think that it was your decision-making?

A. No, it was not my decision-making.

Certainly if it were my decision-making, I would have had blood there faster, I would have had the operating room available quicker, I would have had things that they didn't have available immediately before starting; for example, they

didn't have the rapid blood transfuser, which is a device that's used to compress blood and push it in at a fast rate in there. I would have wished that there had been a central line, not a 22 gauge line.

Q. 20 gauge.

A. 20 gauge line.

There are a lot of things -- I wish they had more staff in terms of phlebotomist and blood bank personnel. I wish that they would have followed the orders for a massive transfusion protocol, if it existed.

I would have loved to have had many things that I didn't have the luxury of having at that time in the face of an obstetrical emergency.

I believe everyone generally speaking did the best they could as quickly as they could.

Q. But, having said that, do you believe that this time period and the things that weren't done was within the standard of care for this lady or not acceptable?

A. I'm not going to render that opinion. That's for your expert to decide.

Q. It was your patient.

So do you believe -- all the things that you just said that weren't done, that weren't ready,

that they didn't have, do you believe that those -- was that acceptable to you, any of that?

A. No.

And I did protest later. But, as I said, one of the ways they shut you down is, they immediately suspend you so you can't do your own internal investigation as to how did it come to pass that so many things didn't meet my personal standard, and to prevent you from being critical outside the -- what you already knew at the time. Okay.

For example, I would have preferred her to be in a surgical ICU than a medical ICU. Certainly if that were possible, I think that would have been a better thing to do.

I learned a lot about what can't happen in a facility like Good Sam. And that was one of the things that led me not to reapply for privileges.

Q. Okay. Doctor -- you said Dr. Duclas and Dr. Brown assisting were the anesthesiologists during the procedure.

Dr. Tomaselli was the assistant --

A. Surgeon.

Q. -- surgeon.

Okay. And it says I think it's Dr. Duclas

note as opposed to Brown. It says on the anesthesia record, "Patient arrived OR" -- I don't know what AMS means, but I'll go to the next word -- "extremis, cold, clammy, blood gushing from vaginal canal."

Is that accurate in your -- from your memory?

A. I've never known an anesthesiologist who's at the head of the table near the mouth and the face to be able to visualize a patient whose legs are typically strapped, blood gushing anywhere --

Q. Is it --

A. -- from a vagina.

Q. I mean, he could have gotten that information from you, he could have gotten it from the nurses, or he could have seen it before he got to the operating room; right?

A. Well, like I said, I find that interesting. I can't wait to read his depo. Let's just leave it at that.

Q. Okay. But more importantly my question at this stage is, do you disagree with that characterization of her being in extremis, cold, clammy, and blood gushing from the vaginal canal, can you say any of that did not happen?

A. As I said, again, for an anesthesiologist, who's, generally speaking, at the opposite end of the body than the vagina, I'm not sure if what he is saying -- I don't know on what basis he made that observation or if that was hearsay.

Q. I'm not asking you to say whether it was right or wrong, what he said.

I'm asking if you have any knowledge as to whether or not you saw the same things, or you don't remember one way or the other?

A. Oh, I remember the vaginal bleeding. I just don't remember the vaginal bleeding in the operating room, because at that time her legs were closed and she was strapped and then she was covered up.

Q. Okay. So during the procedure itself you've already told us that you decided at some point to do a supracervical, meaning above the cervix, hysterectomy. But you also decided to leave in a portion of the uterus, the part that had actually been actively beading; correct?

A. Oh, now we're agreeing that that's the part that was actively bleeding, the lower uterine segment. Okay. Now that I've got that on the record, thank you.

I just want to say this: The only way to stop a blood vessel that's bleeding is to ligate it.

Q. Not remove it?

A. Well, you're going to have ligate some part of it unless you -- you know, unless you remove something that --

I mean, we don't take the heart out. I mean, you've got to pick a point where you can stop.

Q. The heart is necessarily to live, the uterus is not, it's only to have babies; right? Right?

A. Among other things. Yes.

Q. Okay. So if you took out -- if you made the decision to take out the entire uterus and the cervix, there's no place for her to bleed from, is there?

A. The vaginal cuff.

Q. But she never bled from the vaginal cuff?

A. She would if you cut it.

Q. Not if you sutured it after you took out the uterus.

A. Same thing with the cervix or the lower uterine segment.

In fact, there's a recognized operation for controlling postpartum hemorrhage where you

actually leave the entire uterus in and you sew up the uterus using wide sutures that you tie and ligate.

So the spectrum of options that you have range from, you leave the entire uterus in all the way to you remove the uterus and the cervix. And the doctor has the ability to make that judgment call as to where he thinks the bleeding is coming from and what is it that he actually needs to do to stop the bleeding.

And I can tell you with certainty that she was not bleeding from the lower uterine segment that we left, or the top of the cervix, which we also left, because by direct visualization two Board certified OB/GYNs saw that there was no further intra-abdominal bleeding towards the conclusion of that surgical procedure.

Now, if you remove the cervix, you might get into the bladder, you might get into the rectum, you might get into adjacent tissues that could cause further bleeding.

Having known by direct visualization that her cervix was completely dry, that the bleeding was coming from the inside of her uterus, by closing her in the manner -- by operating in the manner we did

and doing the surgery exactly in the manner that we did, I know with certainty that at the conclusion of that operation her bleeding had stopped from her uterine source. Even if we left a little piece of uterus in the lower uterine segment in the body, it was not going to hurt her, it was not bleeding. We sutured it up under direct visualization.

And it was an appropriate thing to do because the -- one of the guidelines is to try to do whatever it takes to control where the source of bleeding is thought to be coming from. And that's what we did.

Q. Wouldn't removing the entire uterus take away the possibility of any further uterine bleeding?

A. Not necessarily, because, as I said, within the spectrum of what's allowed, you can actually leave the whole uterus in, tie off the uterine blood vessels alone. You can tie up the uterine blood vessels, the blood vessels that run parallel to the sides of the uterus. That's allowed. It's called an uterine artery ligation. You can even do -- you can even leave the uterus in and sew up the uterine body, the corpus of the uterus, and leave the entire uterus.

Q. You're saying --

A. You're coming to a conclusion that isn't supported by the evidence.

Q. The Department of Medicine came to the same conclusion, didn't they?

A. Excuse me?

Q. The Department of Medicine came to the same conclusion, that you should have done a total hysterectomy.

A. The Department of Medicine --

I'm not sure I understand.

Q. The Department of Health, when they filed a complaint against you in this case which is pending right now, wrote in that complaint, and I'll show it to you if you need to, that you deviated from the standard of care in failing to do a complete abdominal hysterectomy.

A. Correct. That's their opinion.

I remember they had an opinion once in a case I was involved in where a baby was born in a helicopter on the way to the hospital, and they wanted to take that OB/GYN, who was waiting at the hospital, license away.

That was the complaint that was written.

Q. Okay. So now when you did -- you

mentioned Dr. Tomaselli was there, specifically, two Board certified OB/GYNs.

Is it your testimony that Dr. Tomaselli was aware that you were leaving part of the uterus and the cervix in?

A. I don't know.

Q. Okay. It was your decision, however, to do so?

A. That's correct.

Q. Okay.

A. Because I knew with certainty, by having sutured that tissue and seeing that tissue and seeing -- and observing for a period of time where we both watched the pelvis area, that the bleeding had stopped.

Q. Okay.

A. By the way, not only did we do that, but he also sewed up the uterine arteries. And the uterine arteries on both sides were ligated.

Q. Okay.

A. Which is another recognized technique of stopping a postpartum hemorrhage.

And in some cases they leave the uterus inside, the entire uterus, and all they do is sew up the uterine arteries.

Q. Have you ever done that?

A. Yes.

Q. Okay.

A. I've done that. I've done the sutures only.

Q. Massive postpartum hemorrhage --

A. Postpartum hemorrhage.

Q. Excuse me. Let me finish.

A. Oh, I'm sorry.

Q. Massive postpartum hemorrhage with a lady who was in this type of condition, you've -- where you've thought that the bleeding was coming from the uterus, you've opened them up and left the uterus in and just sewed it up?

A. Sewed up the uterine artery. Yes, I've done that.

Q. Okay.

A. Because what happens is, as what happened in this case, when we actually clamped the uterine artery bilaterally with I believe there were Kelly clamps, her blood pressure went up. And it wasn't because the resuscitation at the anesthesia level had changed. It's because that was another clue that the bleeding -- you know, the tributary -- the blood supply leading up to the bleeding stopped at

the uterine artery.

Q. Okay.

A. Because her blood pressure immediately went up.

And because of that, I knew it was safe for us to perform a supracervical hysterectomy, and it was appropriate for us.

Q. One of the other reasons that the blood pressure went up is that she was finally given blood products?

A. Not in enough quantities to justify at the time of the occlusion of the uterine artery. That's not the case.

The reason is -- it was immediately --

You're saying that immediately when we put the clamps on those uterine arteries was at the exact amount of time that a massive amount of blood was transfused, in the absence of an appropriate central line, in the absence of a --

Q. No, I didn't say that.

A. -- in the absence of the blood pressure -- blood transfuser, the rapid blood transfuser machine, which was not available, and at the same time that there was sufficient blood in the hands of the anesthesiologist, they just coincidentally all

three of those things happened after we clamped the uterine artery.

That doesn't make surgical or logical sense to me as a surgeon with 30 years of experience.

The reason her blood pressure went up was, the root source, the root tributary that was leading blood to go to the cervix and the uterus were stopped. That's why that technique works.

Q. Okay. So when you finished --

So we're clear, just tell me if you recall what part of the surgery was done by you as opposed to Dr. Tomaselli, or if he did any part, or if he was just standing there if you needed him?

A. I believe I did my side of the operation, in terms of the upper vessels. He did his part of the upper and lower vessels. And I did the removal of the lower uterine segment while leaving her cervix in.

Q. Now, immediately postop, while she was still in the operating room, were you called back to the table by either Dr. Tomaselli -- excuse me -- Dr. Duclas or Dr. Brown or the nurses about a problem?

A. Yes. They were concerned about oozing

coming from the right side of the surgical incision.

Q. She was bleeding through the gauze on the surgical incision, in other words?

A. Correct.

Q. And did Dr. Duclas or Brown or anyone else ask you whether you should reoperate on this patient, open her up again?

A. Would you consider that she needs to be reoperated on, is I believe the question.

And the answer was, I would like for her coagulations to be corrected before we reexplore her, if it is even necessary.

I think that the amount of bleeding I saw clinically -- because I did go back into the operating room and observe what they were observing.

I wanted to put the pressure dressing on, which was an abdominal binder, which is like a girdle, big girdle, and then a big girdle with an ice pack, to see if the bleeding was being caused by the edge of what we had cut with a scalpel or whether it was some other type of bleeding.

Q. Okay.

A. Now, because we did that did not mean that we excluded completely the possibility of re-exploration if it was indicated.

But at that time her vital signs were normalized, her oxygenation, I was told, was normalized, her -- when I say her vital signs, I mean her blood pressure and pulse. The urine that she was actually producing in the Foley bag, the fresh urine was clear, not blood tinged.

So on the basis of the hemodynamic status, even though she may have had some edge bleeding or bleeding maybe a little bit below the skin, I felt that that could be treated conservatively initially, but not to the exclusion of having to reexplore her.

And I was reassured, actually, at that time, because Dr. Duclas says, well, okay, I'm going to stay here tonight and I'm going to keep an OR team available in the main OR in the event you change your mind.

And I said that would be fine. If something changes, then we'll reexamine the situation and go from there.

Q. Okay.

A. And I placed orders, including a repeat blood count to be done as part of the postoperative orders.

Q. And --

A. And the transfusions were in progress at

that time.

But unbeknownst to me, because I didn't really look over the top of the curtain, there was no central line.

Q. And there was no platelets being given?

A. There was no platelets being given. There was no fresh frozen plasma being given at the time I last saw the patient in that room. And there was no rapid blood transfusion -- rapid blood infuser device, which is a bag pressure device that would push blood in quickly.

Q. And there was no central line to push it through?

A. That's right.

Q. And whose job is it to do that in this case?

A. Well, I'm going -- I would generally defer that to the anesthesiologist Dr. Brown or Dr. Duclas.

I would never have expected Dr. Tomaselli to go to the head of the table and start a central line, because it's out of our -- we're not allowed by the permissions that a hospital allows us to do -- neither he nor I could have put in a central line.

Q. So that being the case, and the fact that there was two anesthesiologists there --

A. In the OR. Yes.

Also, I've seen intensivists put in central lines. And I've seen interventional radiologists put in a line.

Q. In this particular case, however, you believe that a central line should have been inserted even before surgery; correct?

A. Correct.

Q. And that the only people there that were present that would have done that would have been the anesthesiologists?

A. Correct. Of the people that I saw there, yes.

Q. And it wasn't done?

A. No, it wasn't done.

Q. Did you ever question why it wasn't being done at the time, or did you not know?

A. During the surgery I actually asked are we putting in a central line.

Q. You asked Dr. Duclas?

A. They were both there.

Q. And Brown?

A. They said not yet.

Q. Okay. Any more discussions about that between you and the anesthesiologists?

A. No, not that I can recall.

Q. Okay. Dr. Duclas' note, postoperative note is that her main medical issue was that she had blood seeping through her incisional wound. The wound bleeding was brought to the surgeon's, in parentheses, Dr. Lopez, attention by the nurse, the OR nurse and myself, because we were concerned about internal bleeding, but deferred to the surgeon to make the appropriate assessment. We called the surgeon back into the operating room. Upon inspection of the incision, the surgeon did not think that reopening the patient while she was in the OR was necessary and he ordered the wound to be compressed with an abdominal binder.

That's what you told us already; correct?

A. Yes.

Q. "I informed the surgeon that internal bleeding could be worth considering with more suspicion because" --

I'm sorry. Dr. Duclas's note goes on to say --

A. Okay.

Q. -- quote, I informed the surgeon that

internal bleeding could be worth considering with more suspicion because of the majority of blood control may have occurred under hypotensive conditions and since the patient's blood pressure was since normalized, there may be a new vascular bleed that may not be present and worth further investigation or reopening. He still thought binding was appropriate. So the patient was transported from the OR to the ICU as planed and with binding as ordered by the surgeon.

Do you remember the second part of that conversation that Dr. Duclas noted, that he raised a concern?

A. Yes, he did.

Q. As he said, you decided that despite what he said you didn't think it was -- the operation was appropriate at that time?

A. Correct. That was correct.

Is this 5 o'clock in the morning note?

Q. No.

I don't know the note --

It's timed -- dictated, according to this, at 27 minutes after midnight. It is --

There's 4:30 -- that's a different note.

A. What page is it on?

Q. 6 o'clock in morning. You're right.

A. Oh, so this is after she was already dead when he dictated this; right?

Q. Yes.

A. Okay. So this was the note he dictated to cover his ass after she was dead.

Q. I see.

A. Keep going. That's fine. I remember.

I read this note.

No, so far I agree up to the point that you read.

Q. Okay. "Upon arrival in the ICU the patient was stable, but still having blood stained abdominal pads or her wound when checked by the OR nurse, but it was similar to the bleeding that was shown to the surgeon while the patient was still in the OR."

Again, is that consistent with your thinking that she didn't need to go back or --

A. That and more. Because in real time before she died, I had actually called and spoken to the OB nurse Ryan, who I asked -- and I'm going to guess that was a little bit past midnight. I had left the hospital. I called to check on the bleeding, the abdominal bleeding status. And she

had said that it had improved or stopped. She had not gotten more information otherwise. And I had asked about the labs that I had ordered postoperatively, and I believe she went to the computer, and they weren't back yet.

Q. Okay. Should they have been?

A. I don't remember the time -- you know, my time gets a little bit warped in terms of when my order went in, I don't know if it was -- I ordered them two hours or four hours, but I could look and find out.

Q. Okay. So Dr. Duclas's note goes on continuing from where I left off, quote, there was no visible change in the size of the abdomen or any tightness or firmness felt by me or the nurse providers. Abdominal binding persisted. I chose to remain in the hospital despite being able to continue call at home because I was still concerned about the possibility of re-bleed internally under the binding. I did not retreat to my call room unless I had witnessed the patient make purposeful movements and respond to the ICU nurse's voice. At one point I was informed about a blood gas that was suggestive of a metabolic acidosis, but the therapy was being handled by the ICU team already with

fluids, bicarb and pressor drip was started -- was going to be started. However, patient decompensated.

And, you know, they talk about the code.

A. Okay.

Q. So you're saying --

And, also, I'll read it if you need me to, the nurse noted that -- the same thing as Dr. Duclas, that she called you and was worried about beading and that she saw you walking out of the hospital. There's a to that affect.

Is that accurate, that you did leave the hospital after surgery?

A. Yes, I did.

And let me tell you why. I actually had saturated one of my -- my scrub pants the lower portion below the knee of my scrub pants in blood, and there were no fresh scrubs in the call room. So I left the hospital to go home to get out of the blood soaked scrubs. Additionally, my sock and my shoe were filled with blood clot from Miss Castillo-Lopez. So in order to wash myself, I went home.

I knew that I left her in the hands of two anesthesiologists, an intensivist, an experienced OB

nurse Ryan, who I'd worked with for years, who was used to recovering postop cesarean section patients on a regular basis. And from my conversation in the medical ICU by phone with an experienced but young medical ICU nurse, and I had asked them about the bleeding, the abdominal speeding and the vital signs.

Q. Okay.

A. So while I may not have been physically present, I also knew that inside that hospital there was a hospitalist, an M.D. that had heard about the previous code, rapid response code.

Q. Okay.

A. So I felt comfortable that if I wasn't physically in the hospital that I could promptly be physically in the hospital if the vital signs or there was a need that arose.

I was never called or contacted by the nurses, by Dr. Duclas or the hospitalist or the intensivist or the ICU nurse at any time. I called them. They never called me.

In fact, I called a second time because the labs were not back the first time I called, and I got the reports of the lab work, which seemed reasonable on the basis of the amount of blood that

I had queried the ICU nurse, the MICU nurse. I'm trying to remember her name. But -- not Ryan, but the one that was there that had kept up the count of how much blood she had received.

Q. Vida Joseph?

A. That's right.

Q. Miss Joseph noted that she received the patient in the ICU from the OR at about it says midnight, 0000 hours. Report received from Dr. Duclas. Patient intubated. No sedation.

Was the patient intubated before the hysterectomy?

A. Yes.

Q. Okay. And she said that the patient had tachycardia in the 140's on the monitor, hypotension noted, so a two liter bolus infusing per anesthesia. Abdominal dressing saturated with bloody drainage. And abdominal binder in place. Dressing removed and changed with anesthesia present at bedside. The abdominal binder was reapplied. Bloody drainage noted draining into Foley as well as out of the vagina. Fresh peri-pad applied. Intensivist noted of patient and seen on Nuview. Will continue to monitor and carry out orders.

Is that information -- anything in that

information new to you, information that you didn't know about?

A. What time was that note written?

Q. Midnight.

A. Okay. I had called shortly after midnight and received a different kind of report.

That would have been the first dressing change.

I did not expect the vagina to be 100 percent absolutely hemostatic for two reasons; in addition to the cervical lacerations which I repaired, I repaired a perineal laceration, a second degree vaginal laceration from the birth of the child. This was not a laceration that I had cut. It's not episiotomy, where the doctor actually cuts it. This is where the patient had actually torn. And at that time the labs were not back.

So depending on her degree of treatment of her coagulopathy, okay, because obviously it would not surprise me in the least bit that she was in DIC of one form or another, some vaginal bleeding was going to be appropriate for the laceration she had in her vagina. The vagina is extremely vascular after you have a child. You do not expect the vagina not to have bleeding.

I was not told that her bleeding was of a quantity concerning, because I also had spoken to Ryan, the labor and delivery nurse, who had, you know, participated in cesarean sections and postpartum female care for a number of years.

So on the basis of that information I felt that even though the patient was still recovering from her acute postpartum hemorrhage that it did not require my reopening her abdomen, resuturing her vagina until I knew the results of her coags, because if this bleeding was due to lack of platelets or lack of the blood components, if it was an abnormal PT or PTT or abnormal platelets, those have need to be corrected. Because before I would have suggested that those would be solely due to lack of suture hemostasis. I asked about the abdominal cavity, whether it was distended, and the answer was no.

Q. When the labs came back were you notified of what they were?

A. I called to get the labs, yes. And they were somewhat reassuring.

Q. Okay. Was --

A. With the exception of the platelet count of 60,000.

Q. I was going to ask you that. So tell me --

A. But she was under the care --

Q. Her platelet count when she came in was like 160, which is normal --

A. Excuse me. When she came into the hospital, you're talking about the her first platelet count?

Q. Yes.

A. I think it was higher than that.

Q. Okay. But it was within normal range?

A. Yes.

Q. Sixty is a huge drop from what it was when she came in?

A. Yes, sir. That's correct.

But in the light of the circumstances of her postpartum hemorrhage --

Q. But why not give platelets to replace that so that you can help avoid DIC or treat it?

A. Excellent question.

And the answer is as follows: The guidelines for transfusion has changed a lot. We used to transfuse to a hematocrit greater than 30. Now you can be 22 before a transfusion could be given. This is from the American College of

Pathology and the hospital policies as implemented, to diminish the number of transfusions that are given.

Spontaneous bleeding typically will occur with a platelet count below 50,000. So a 60,000 platelet count, I'm not going to say to you that everybody would transfuse with platelets at a 60,000 count.

With someone who just went through a heavy bleed would I've expected more aggressive blood product readministration?

Maybe.

But could I be critical?

Well, as I said, I've sat on committees that does reviews for a number of years, and when there was this new change in the numbers that we use for absolute transfusion, it goes into that judgment call circumstance, how is the patient doing clinically in addition to the numbers.

A hemoglobin greater than 21, would I expect absolutely for more blood to be given?

Not necessarily.

A platelet count of 60,000, higher than 50,000, definitely needs to continue to be trended.

If she had evidence of active bleeding

that was important or significant, absolutely I would have expected more blood.

But I had the eyes of an intensivist, Dr. Duclas, who in his postmortem note notes that he was there. I would assume he went by and took a look at the patient himself and took a look at the labs on the computer himself, because he was there, he's physically there. And I received the reports by phone.

And I felt reassured -- more reassured by what I heard from Ryan rather than -- I apologize for the ICU's name, but I forgot her name. But Ryan I knew quite well.

Q. Well, was the patient neurologically was she awake, alert, responding?

A. The report I got -- I was not physically there --

Q. I understand.

A. The report I got is, at first there was a concern about that. But she had showed response to commands. In other words, she was asked to squeeze fingers. I believe one of her relatives at the bedside asked her to squeeze their hand, and they did in response to her name being called. I also heard from the nurse that there was purposeful

movement, there was following an order that the nurse gave to the patient.

And to me that was indication that there was no brainstem injury, that there was no -- that her cerebral cortex, which is what has to be functional for you to move muscles, okay, especially under instruction, so that means that the very top surface of her brain, which is the area that is most susceptible to hypoxic injury, because it's the one part of your brain that is the furthest away from the blood supply, okay, if you're told to do something, then the auditory portion of your brain is working if you respond. Okay. So we know her ears and the nerves that go from her ears to the middle part of her brain that go to the surface of the brain and the feedback loop all the way back down were functional.

Q. Okay.

A. She was not brain dead. She would not pass a brain death test, because she had purposeful movement after instruction by a relative and by a trained professional.

Q. Okay. Nurse Vida noted at midnight, which is when she received the patient, that she had no gag reflex and no cough reflex. She noted that the

patient was obtunded. She noted that the patient was flaccid, best motor response was flaccid. Best verbal response was none. She was intubated. Best eye opening response none.

At 1 o'clock the same things.

At midnight, again, she's noted unable to follow commands. No wiggling of toes right or left, or fingers right or left.

Again at 1 o'clock the same thing, there was no following commands.

At midnight unable to move any of her extremities. Oral assessment, description bleeding midnight.

A. Oral?

Q. It says oral assessment.

A. Like O-R-A-L?

Q. Yes.

A. Okay. I'm sorry.

As opposed to A-U-R.

Q. O-R-A-L.

Assessment, description bleeding.

There was blood -- her urine was bloody, quote, unquote. And her pupils equal and reactive to light, no. Extraocular movements unable to assess. Blinks to threat absent. 2 millimeter

pupils on both sides not reacting.

Were you told that, all of that?

A. No.

Q. What were --

A. I was told that there was purposeful movement. Because there had been an order written for either -- I believe it was a CAT scan if there was an the absence of a purposeful movement after a time. I do not recall what time that was.

And I had asked -- I called somewhere maybe 2:00, 2:30, I called from home. And the report I got that the CAT scan was not performed because she was showing evidence of recovery and purposeful movement.

Now, I believe even in Dr. Duclas's note that you had quoted from 5 or 6 o'clock in the morning -- I don't know what page that's on -- but he even indicates that there was purposeful movement and a decision not to proceed with a CAT scan. They decided to give her more time to see whether she responded better or more.

Q. Well, what does everything I just read to you from the Nurse Vida's note at -- the intensive care unit nurse who took her, all the things I just read to you that were absent, movements, voluntary

movements, pupils, responses, everything I just read to you, what would that indicate to you as opposed to what you just said about her condition?

MR. MIDWALL: Form.

A. Well, we're talking about two different -- two different evaluators. We have an anesthesiologist who puts people to sleep and immobilizes them on purpose, who watches them wake up after they come out of say vascular surgery versus a medical ICU nurse's documentation.

The report I got was more consistent with what I believe Dr. Duclas wrote in his 5 o'clock, 6 o'clock in the morning note, or dictated in his 5 o'clock, 6 o'clock note, than what Nurse Vida had relayed.

And when I came in after she had arrested and spoke to the family, I had also got reassurance that she was showing, you know, movement, purposeful of moment of some sort. And I believe it was hand squeezing on command with a relative, her husband. It might have been her mother.

BY MR. COHEN:

Q. That's not in the record. That's what you remember?

A. That's what I had heard.

I'm telling you --

Yes, I did not document it. She had already passed.

But I had heard -- I had heard from I believe it was Ryan that she had had evidence of purposeful movement and as such they thought she was improving.

There's no question she was critically ill when she came into the ICU.

Q. So we know what the labs looked like at 1:30 or such in the morning. We talked about that a bit.

Did the intensivist, who was called by the Nuview system, ever speak with you?

A. No.

Q. Did -- at 3 o'clock did her condition get worse, do you know?

A. Yes. It acutely -- she acutely deteriorated.

Q. What do you think --

A. Hyper acutely.

Q. Did she have a metabolic acidosis?

A. Yes. But that was being corrected.

Q. What was causing it?

MR. MIDWALL: Form.

A. I would imagine that she had sustained an acute severe hemorrhage.

BY MR. COHEN:

Q. Where?

A. Well, in her -- through her uterus. She had had profound blood loss and she had an acidosis that needed to be corrected, in addition to all the other metabolic elements that might have needed to be corrected, which is not uncommon after a postpartum hemorrhage.

Q. So what caused the acute change in her clinical condition, as you put it?

MR. MIDWALL: Form.

A. I don't know exactly. I can't say.

BY MR. COHEN:

Q. Okay. Other than the massive bleed that she had sustained and the lack of platelets and central lines, the things that you talked about in the intensive care unit, whatever it was, other than the massive bleed that she had, what else could have caused her death, other than the massive bleeding, in your opinion?

MR. MIDWALL: Form.

A. My first impression was, I wonder if she sustained an acute pulmonary embolism.

In fact, the first person who suggested that to me was her aunt, Dr. Irma Lopez, when she came in. Because she, like I, had called in to get the results of the laboratory testing. And she, like I, was under the impression that she had regained purposeful movement. And her labs, while still not as they were when she was admitted, were certainly understandable in light of the amount of bleeding and resuscitation that she had had. It would be consistent with the amount of bleeding and the amount of resuscitation that she had sustained.

Q. She therefore died from the massive postoperative -- post-delivery hemorrhaging that she had and the sequelae of that is what caused her death, more likely than not; correct?

MR. MIDWALL: Form.

A. Again, in light of not having additional review of her pathology slides, I would say it needs -- by another pathologist, I would say it remains to be determined as to her exact cause of death.

BY MR. COHEN:

Q. Well, we know it wasn't a pulmonary embolus, because it was looked for by the pathologist and it wasn't found; correct?

A. As I mentioned before, only one pathologist has taken a look at some of the evidence. I don't know that everyone's -- I don't know that a second expert that would review this case would come to the same or different conclusion, because they've not had the opportunity to review the clinical history or the pathological evidence that we know exists.

Q. Well, actually she did. She mentions the medical records and then quotes from them at the time of her dictation, and -- somewhat at length. And she specifically looked at the lungs to see if there was any evidence of pulmonary embolus and there was not.

Are you questioning that?

A. As I may have mentioned before, I've been in this community 30 years and I've read more than a few postmortem reports from the local, meaning the Palm Beach County Coroner's Office, and I've seen some reports that were consistent with subsequent evaluations by independent medical examiners and I've seen a wide discrepancy between interpretations between separate pathologists.

I am reluctant to accept a single opinion just by this -- not necessarily because it's my

case, but because I've seen times that others have found things and looked for things that were the cause of death that were heretofore unknown at the time or have subsequently developed by further investigation of the same specimen.

So I'm just saying I'm going to withhold my judgment.

I saw what she wrote. Just like I've seen reports of the amount of pressure that the CPR machines placed in terms of the centimeters of compression that you get when you use a machine, CPR machine versus a human CPR effort. And in some cases the amount of arterial pressure that gets generated is sufficient to blow off recently placed sutures.

So the blood that's accumulated is perimortem, not antemortem.

Q. Is there any effort --

Well, first of all, do you think the patient had DIC at any point?

A. I didn't look to -- I didn't really look at that in any sort of serious way.

Q. What is it with this patient's ongoing problems, the bleeding problems that she had, that would lead to a pulmonary embolus?

I mean, the platelet count was low, not high.

A. Right.

But what sometimes can happen is, there's a stasis that's caused -- the stasis of blood.

Q. Right.

A. What I mean by that is, patients who become hypotensive may actually have pooling of blood.

In obstetrics when you give a patient an epidural, you basically diminish the amount of blood pressure that exists in the lower extremities. That's one of the consequences of an epidural. Many times they get hypotensive.

In fact, that's why the anesthesiologists generally hang around awhile after they put in and dose an epidural.

This patient had a epidural.

Sometimes the blood pressure drops so much that they have to give ephedrine, and it's part of their standing orders, if there's a hypotensive episode.

When you have pooling of blood, you increase the likelihood of a clot to form, whether it's caused by low blood pressure from an epidural

or low blood pressure from a postpartum hemorrhage.

She definitely had low blood pressure multiple times for one reason or another. And that predisposes that patient to form a clot. And if that clot goes to the lungs, that's what we call a pulmonary embolism.

Q. And that's something that you see on autopsy?

A. Depends on how careful the specimens are looked at.

Q. Okay. And this lady's last fibrinogen study was 62.

Normal range 200 to 400.

What does that tell you?

A. That she's probably in DIC.

Q. Okay. So somebody in DIC is not going to be clotting, it's the opposite of clotting, it's where the blood can't clot; right?

A. Okay. And I'm going to tell you, patient care is a movie. And you're looking at a blood test. A blood test is a photograph of one moment in time.

If the blood clot formed during the time that she got her epidural and had a drop in her blood pressure, that was corrected by a fluid bolus,

a blood clot could be formed and be waiting there while her clotting factors were all relatively normal.

Q. Not normal. They were abnormal in a way that showed that she wasn't clotting.

A. Sir, that photograph was taken towards her death.

Q. 1:20.

A. When you take a photograph of what was going on in her lower extremities after she got the epidural and her blood pressure dropped, which is a sign that the epidural is doing exactly what it's supposed to do --

Q. What does that have to do with 1:20 in the morning, the epidural?

A. Because if a clot formed --

Q. Hang on.

You're talking about the last blood test that was done on her at 1:20 -- collected at least at 1:20 in the morning, reported after 2:00, 2:23 in the morning. Critical values, it says, with a fibrinogen of 62, a PTT of 61, a PT of 18, and an INR of 1.8, all abnormal.

Those are all evidence that she has less than normal clotting factors, that she's less likely

to clot, not more likely?

A. At that time.

Q. At 1:20, yes.

A. At that time. Okay.

Q. What --

A. What if we took -- what if her low blood pressure caused stasis of blood in her legs when she was undergoing the acute bleed?

What if the low blood pressure caused a pooling of blood when her coagulation factors were normal at the time of her epidural?

If it happened at the time of the epidural, if it happened at the time of her hypotension during her bleed, clots can form that won't be released necessarily instantaneously.

The other thing is, that when you have a patient pushing a baby out, you put their legs up.

And in her case her legs were up. It's a position called semi-phallus. Her legs are elevated in stirrups and strapped, because she's numb from the epidural, and her legs are elevated. And that elevation -- that antigravity elevation also causes pooling of blood in the calves, and a clot can form at that time.

Q. What evidence do you have of that at all?

Any piece of evidence, show me one piece of evidence in this chart that somewhere during delivery she had a DVT?

A. And my answer is this: I'm not saying that I know the cause of her death. Her death to me seems to fit a pattern that I've seen in another case that was similar to this, where there was no postpartum hemorrhage, and it was actually caused by a blood clot that had formed in a patient with an epidural with her feet up.

Q. That has nothing to do with this case, Doctor.

A. And the first pathologist -- excuse me -- the first pathologist said no pulmonary embolism. And another pathologist demonstrated that there was.

Q. But that lady wasn't bleeding to death and needed --

A. I get that. I get that.

Q. And didn't have clotting factors which showed that she was not only anticoagulated or anti-platelets were high, but that she was, in fact, DIC, which is the opposite of clotting.

So I'm sure there's, you know, stories of a lot of people.

But this lady didn't have any evidence, in

fact, had reverse evidence of that happening; correct?

A. Only based on one medical examiner's report.

Q. No.

And based on the laboratory reports that she had.

And not one single person in the medical record wrote that she had a pulmonary embolus, did they?

A. Well, let me refer you to this page.

Very interesting you should mention that.

But I think over here, and I'm going to have flip some pages --

Q. Okay.

A. You're going to have to give me a moment.

We might even have to go off the record.

Q. Okay. Let's go off the record for a minute.

(Whereupon, an off the record discussion was held.)

THE WITNESS: On page 72 of my Bate stamped record.

After a discussion with Dr. Irma Lopez, who had also received the same lab information

approximately at the same time I did, sometime around 2:00 in the morning, somewhere before 2:00 to 2:45, pulmonary embolism is checked off as the preliminary cause of death. And this record --

BY MR. COHEN:

Q. By who?

A. It says by the --

Did attending physician indicate preliminary cause of death?

The answer was yes. And it says pulmonary embolism.

BY MR. COHEN:

Q. Excuse me. May I?

A. Sure.

Q. Who was that physician?

A. They called me. She said Berto Lopez.

Q. Right.

You came up with that idea; right?

Not anybody else.

A. No. Irma Lopez, her aunt.

Q. Irma Lopez is a family practitioner who would have -- can speculate all she wants -- would have no knowledge of pulmonary embolus. And she didn't know all the bleeding factors. And she

didn't know how much she had bled and all that other stuff.

You're the one who signed off on this as being a potential pulmonary embolus, not anybody else; right?

A. My name doesn't sign off -- I don't see my signature anywhere on that page.

The reason that exists is because Irma Lopez and I spoke with Vida Joseph, and at that time that was her and my initial conclusion of the cause. And it is in writing. And I guess this page is called Expiration and Release of Body, page 1 of 2.

Q. She actually had a cardiac, not a respiratory arrest.

She was intubated at 3 o'clock; correct?

She had already been intubated.

And they checked off cardiac arrest and left off respiratory arrest. Didn't check that box.

Doesn't that tell you something?

A. I have no opinion about that.

Q. Well, if you have a pulmonary embolus, you have a respiratory arrest primarily and then cardiac, you don't have a cardiac arrest first; right?

A. Again, I'm not an expert on either of

those.

Q. Okay.

A. This was what I was -- when I spoke with Dr. Irma Lopez --

Q. Dr. Irma Lopez is not an expert witness and she's not an expert at all on any of this. She's a family practitioner; correct?

A. I'm just relaying what she said.

Q. Would you take her word or her guess over that of a -- someone who did the autopsy?

A. Well, again, it depends on who that person that did the autopsy and with what care.

Q. She's been doing autopsies for 30 or 40 years, this lady. And she, by the way, does not work for the Palm Beach County Medical Examiner's Office. She's an independent medical examiner.

A. I'm sorry.

Q. But she did the autopsy. She had the lungs in her hands, both macroscopically and microscopically, and found no evidence of a pulmonary embolus; correct?

A. That's what her report says, yes.

Q. Okay. And according to the code blue sheet, which was filled out by the -- one of the nurses, Vanessa -- excuse me -- there was a doctor

there, Vanessa Vasquez. There were nurses there who recorded things, including this specific note, she recorded this. The etiology was cardiac arrest at 3:00 a.m. Respiratory is left unchecked. It was witnessed at 3:00 a.m. She had pulseless electrical activity. And CPR was started. And they gave various medications to try to bring her back, but unsuccessfully, for 55 minutes.

And nobody in that room said anything about a pulmonary embolus, did they?

A. Not on the record, no.

Q. Did any of them say that off the record to you?

A. Yes. I told you, Dr. Irma Lopez.

Q. Dr. Irma Lopez was not one of the doctors in the code blue, Doctor.

A. Correct.

Q. I'm asking you about the doctors who performed the code blue, did any of them say they thought it was a pulmonary arrest or pulmonary embolus, either one?

A. I did not speak with Dr. Vasquez.

Q. Okay. You were there when she died, were you not?

A. No. I came after she was dead.

Q. I thought I read in the records somewhere that you were there during the code.

You're saying you were not?

A. I was there at the end of the code, towards the end of the code. Correct.

Q. That's what I'm getting at.

A. I pronounced her dead after 45 minutes of resuscitative efforts.

Q. Right. Okay. That's all I was asking.

A. Yes.

Q. Is it your testimony that -- after everything we've gone over today that you don't know whether or not she died as a result of the massive bleed that she had?

A. I am -- I have no opinion at this point pending further review as to the exact cause of death.

Q. Okay. The medical examiner Dr. Price indicated that she had retained lower uterine segment, with raggedy cervix containing multiple sutures, on autopsy.

Do you have any reason to disagree with that?

A. I was the one that placed those sutures.

Q. Right. That's why I was saying do you

have any reason to disagree --

A. No. That was intentional.

Q. Yes. I understand that.

She also had a hemoperitoneum, 1500 cubic centimeters of liquid blood in the peritoneum.

Any reason to disagree with that?

A. No.

Q. She said that one of the causes of death was hemorrhagic shock with multi-organ failure.

Any disagreement with that?

A. No.

Q. And that she had evidence of DIC?

A. I agree with that.

Q. So her final opinion that she wrote as to the cause of death was, she was a 40 year old female who died as a result of complications of hemorrhagic shock with multisystem -- multi-organ failure and DIC due to postpartum hemorrhage due to uterine atony.

You wouldn't agree with any of that, would you?

A. No.

MR. COHEN: Okay. All right. I don't think I have any further questions for you at this time, sir.

Anyone else?

CROSS EXAMINATION

BY MR. BARKER:

Q. Dr. Lopez, my name is Alex Barker, and I represent Dr. Tomaselli.

Do you have any criticisms as it relates to Dr. Tomaselli?

A. No, I do.

MR. BARKER: Thank you. That's all I have.

CROSS EXAMINATION

BY MR. MIDWALL:

Q. And I think you testified earlier you had no criticisms about any of the other medical providers in this case; is that correct?

A. That's correct.

MR. MIDWALL: I've got nothing else.

MR. CHIMPOULIS: No questions.

REDIRECT EXAMINATION

BY MR. COHEN:

Q. Other than the ones you already provided, correct, Doctor?

A. Yes, sir. That goes without saying.

MR. COHEN: Okay. You have the right to read this deposition or waive the reading and

signing of the deposition.

THE WITNESS: I would like to read it.

You're in palm Beach County; correct?

MR. COHEN: Phipps Reporting.

(The proceedings concluded for the day at 3:14 p.m.)

CERTIFICATE OF OATH

STATE OF FLORIDA

COUNTY OF PALM BEACH

I, the undersigned authority, certify that BERTO LOPEZ, M.D. personally appeared before me and was duly sworn on the 10th day of January, 2019.

Signed this 12th day of January, 2019.

Richard Applebaum

RICHARD APPLEBAUM, RMR, FPR, CLR
Notary Public, State of Florida
My Commission No. FF 243089
Expires: 08/06/19

CERTIFICATE OF REPORTER

STATE OF FLORIDA

COUNTY OF PALM BEACH

I, RICHARD APPLEBAUM, Registered Merit Reporter, do hereby certify that I was authorized to and did stenographically report the foregoing videotape deposition of BERTO LOPEZ, M.D.; pages 1 through 197; that a review of the transcript was requested; and that the transcript is a true record of my stenographic notes.

I FURTHER CERTIFY that I am not a relative, employee, attorney, or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorneys or counsel connected with the action, nor am I financially interested in the action.

Dated this 12th day of January, 2019.

Richard Applebaum

RICHARD APPLEBAUM, RMR, FPR, CLR

January 12, 2019

BERTO LOPEZ, M.D.
1501 Presidential Way, Suite 21
West Palm Beach, Florida 33401

Re: Jorge Romero vs Berto Lopez, M.D.
Case No.: 2018CA011332XXXXMB

Please take notice that on the 10th day of January, 2019, you gave your deposition in the above cause. At that time, you did not waive your signature. The transcript is now available for your review.

Please call (888)811-3408 or e-mail production@phippsreporting.com between the hours of 9:00 a.m. and 4:00 p.m., Monday through Friday, for access to a read-only PDF transcript via computer.

Please execute the PDF-fillable Errata Sheet which will be forwarded to you by Phipps Reporting. The Errata Sheet can also be downloaded from www.phippsreporting.com. Once completed, please print, sign, and return to us for distribution to all parties.

If you do not read and sign the deposition within a reasonable amount of time, the original, which has already been forwarded to the ordering attorney, may be filed with the Clerk of the Court.

If you wish to waive your signature now, please sign your name in the blank at the bottom of this letter and return to the address listed below.

Very truly yours,

RICHARD APPLEBAUM, RMR, FPR, CLR
Phipps Reporting, Inc.
1555 Forum Place, Suite 200E
West Palm Beach, Florida 33401

I do hereby waive my signature.

_____

BERTO LOPEZ, M.D.

ERRATA SHEET

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ENTER CHANGES ON THIS PAGE

In Re: JORGE ROMERO VS BERTO LOPEZ, M.D.
Case No.: 2018CA011332XXXXMB
BERTO LOPEZ, M.D.
January 10, 2019

PAGE	LINE	CHANGE	REASON

Under penalties of perjury, I declare that I have read the foregoing document and that the facts stated in it are true.

_____ _____

Date BERTO LOPEZ, M.D.

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